hcpc health & care professions council

Council, 3 December 2014

Correspondence with British Association for Applied Nutrition and Nutritional Therapy (BANT)

Executive summary and recommendations

Introduction

On 4 September 2014, BANT wrote to the HCPC with a petition seeking amendment of the dietitians part of the HCPC Register to provide for the regulation of nutritional therapists. A request was also sent to the Privy Council.

This petition, our response and subsequent correspondence with BANT is appended. In summary, our position, based on legal advice, is that amendment of the Register in the manner requested would be ultra viries. Further, that the standards of proficiency for dietitians have to be set at a level required for safe and effective practice and cannot be varied in the manner described.

To date no subsequent correspondence has been received.

Decision

The Council is invited to discuss the attached correspondence.

Background information

A register of Nutritional therapists is maintained by the Complementary and Natural Healthcare Council (CNHC), which is accredited by the Professional Standards Authority for Health and Social Care (PSA).

Resource implications

None

Financial implications

None

Appendices

- Letter and enclosures from BANT to HCPC dated 4 September 2014
- Letter from HCPC to BANT dated 1 October 2014
- Letter from BANT to HCPC dated 14 October 2014
- Letter from HCPC to BANT dated 4 November 2014

Date of paper

19 November 2014

BANT®

British Association for Applied Nutrition & Nutritional Therapy

4 September, 2014

By Courier

Dr Anna van der Gaag
Chair of the Health and Care Professions Council
Park House
184 Kennington Park Road
London
SE11 4BU

Dear Dr van der Gaag

Formal Request to Modify the Statutory Register for Dietitians

The British Association for Applied Nutrition and Nutritional Therapy ("BANT") hereby formally requests that the Statutory Register for Dietitians is modified so that entry for nutritional therapy practitioners is expressly provided for. Our formal request and supporting documents are enclosed.

Yours sincerely

Miguel Toribio-Mateas
BANT Chair

Enclosure

British Association of Applied Nutrition and Nutritional Therapy – Registration No: 3333951
Registered Office: 5 North Street, Hailsham, East Sussex BN27 1DQ

Request for Modification of the Statutory Register for Dietitians

Submitted to the Chair of the Health and Care Professions Council

By the British Association for Applied Nutrition and Nutritional Therapy

Cc: Lord President of the Privy Council
Secretary of State for Health

4 September 2014

FORMAL REQUEST TO THE HCPC

Dear Dr van der Gaag

The British Association for Applied Nutrition and Nutritional Therapy ("BANT") is writing to request a modification of the statutory register for dietitians so that entry for nutritional therapy practitioners is expressly provided for. Our request is set out in more detail in this dossier and accompanying annexes. In summary, it has become clear over the last several years that there is a significant amount of public, patient and professional confusion over the differences between dietitians and nutritional therapy practitioners. Further, despite both professions operating in the field of nutrition, there are differences in the education and competency standards required for each as well as differences in how the professions practice each speciality. This creates risk to service users. A good example is that nutritional therapy practitioners are more familiar with administering herbal preparations for an individual patient and that this area of practice is supported by accredited competencies that must be met, whereas dietitians do not yet have competencies in place. Indeed, the Secretary of State for Health asked the HCPC in 2011 to establish an individual register for such herbal practitioners.[1] Such an individual register has not yet been established.

Modifying the dietitian's register to cover nutritional therapy would therefore serve a number of purposes. *First*, it would bring nutrition health professionals under the scope of a single, statutory register. For the reasons we set out in more detail below, we consider that a single register for nutrition covering both dietitians and nutritional therapy practitioners is both *necessary* and *expedient* for the purpose of securing and improving the regulation of the profession and the services that the profession provide. In particular, there is a compelling case that regulation would remove patient confusion and ensure patient safety by raising standards within the profession. As such, it meets the legal test for the modification of a register pursuant to Article 60(1)(a) of the Health Act 1999. *Second*, it would meet in large part the Secretary of State's objective to regulate herbal practitioners given that nutritional therapy practitioners administer herbal preparations. Modification is therefore a proportionate and cost-effective means of achieving that objective for a significant proportion of herbal practitioners. *Third*, it would meet the objective of the Human Genetics Commission 2003 'Genes Direct' report where they state that practitioners using genetic tests should operate under standards as stringent as those for doctors, nurses and pharmacists.[2] *Fourth*, a single statutory regulator is consistent with fundamental principles of fairness, equality, non-discrimination and competition in the practice of nutrition whilst ensuring that high standards of consumer protection are maintained.

We are grateful in advance for your prompt attention to this matter. We request that this formal request is considered at the HCPC's next quarterly meeting on 24 September 2014. Given the nature of the request, we have copied the letter to the Secretary of State for Health. We shall

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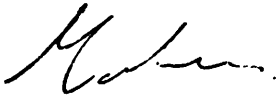
[1] Department of Health announcement about the regulation of herbal practitioners - including questions and answers, 18 February 2011. See http://www.mhra.gov.uk/NewsCentre/CON108789

[2] Genes Direct, Ensuring the effective oversight of genetic tests supplied directly to the public, Human Genetics Commission, 2003. See http://webarchive.nationalarchives.gov.uk/20070205104008/http://hgc.gov.uk/UploadDocs/Contents/Documents/Genes%20direct%20-%20FULL%20REPORT%20FINAL.pdf

also be making a similar request for modification to the Lord President of the Privy Council pursuant to its own powers to make such modifications (see Legal Basis for the Request below).

We remain available to discuss this with you further or provide additional supporting information. We look forward to hearing from you at your earliest convenience and, in any event, no later than four weeks from now. We reserve all of our legal rights in relation to this request.

Yours sincerely



Miguel Toribio-Mateas
BANT Chair

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1. LEGAL BASIS FOR THE REQUEST

This request is made pursuant to Regulation 6 of The Health and Social Work Professions Order 2001 ("2001 Order"). This provision provides the legal basis for the HCPC to make modifications to the register. Specifically, Regulation 6(3)(e) provides that a specified part of the register may be sub-divided into two or more parts. In this case, we propose modifying the register for dietitians to create a single register for "*Dietitians and Nutritional Medicine Practitioners*" that is divided into two parts. As stated above, we shall be making a similar request to the Privy Council pursuant to its own powers to make modifications to the Register under Regulation 6 of the 2001 Order, i.e., "*on a proposal by the [HCPC]* ***or otherwise***" (emphasis added).

In addition, Regulation 6(2) provides that there may be one or more designated titles for each part of the register "*indicative of different qualifications and different kinds of education or training and the registrant is entitled to use whichever of those titles, corresponding to the part of the register in which he is registered, as is appropriate in his case.*" We therefore propose maintaining the existing protected title of "*Dietitians*" for those persons who satisfy the registration requirements for dietitians, and a separate protected title for "*Nutritional Medicine/Therapy Practitioners*" or "*Functional Medicine Dietitians*" for those persons who satisfy criteria that currently applies to nutritional therapy practitioners. Registrants that satisfy the educational and competency standards for both can of course use both titles.

2. NUTRITIONAL THERAPY

2.1 About BANT

BANT is a non-profit organisation, incorporated in 1997 as a Company Limited by Guarantee, which acts as a professional body for nutritional therapy practitioners. It is funded by member subscriptions and donations with a governing board elected by its members. BANT's mission is to:

- act as a professional body for nutritional therapy;
- promote practitioners and those working in the wider application of nutrition science;
- promote high standards of education, training, practice and integrity in the nutrition profession;
- promote the application of nutrition science for optimal health, disease prevention and patient care; and
- work towards the goal of having nutritional therapy available to all on the National Health Service ("NHS").

With over 1,300 full members and 1500 students on accredited courses, it represents the interests of its members and nutritional therapy more generally, and supports Continuing Professional Development programmes. Nutritional Therapy is regulated by the Complementary and Natural Healthcare Council which was set up in 2008 with funding from the Department of Health and in 2014 received Assured Voluntary Register status by the Professional Standards Authority.

In 2014, the newly established Nutritional Therapy Education Commission, an arm's length BANT committee, took over from the Nutritional Therapy Council as the accrediting body for both BANT and the CNHC. NTEC is currently drafting competences for advanced practice using genetic profiling. Interim Standards of Proficiency anticipate underpinning knowledge in genetics, genomics and complexity science, as well as an appreciation of ethical, legal and social issues. These will be issued for a public consultation in the coming months.

BANT has a UK-wide network of area co-ordinators who organise support for local practitioners.

2.2 Nutritional Therapy as a Profession

Nutritional therapy is a well-established profession that meets the nine criteria laid down by Lord Benson in 1992 as set out below:[3]

> 1. *The profession must be controlled by a governing body which in professional matters directs the behaviour of its members. For their part the members have a responsibility to subordinate their private interests in favour of support for the governing body.*

The governing body for nutritional therapy practitioners is BANT. The primary function of BANT is to assist its members in attaining the highest standards of integrity, knowledge, competence and professional practice. BANT practitioner members must have met the required standards of training, be fully insured and adhere to the CNHC and BANT Codes of Practice.

> 2. *The governing body must set adequate standards of education as a condition of entry and thereafter ensure that students obtain an acceptable standard of professional competence. Training and education do not stop at qualification. They must continue throughout the member's professional life.*

Skills for Health, the UK skills sector council, established the National Occupational Standards ("NOS") for Nutritional Therapy which were published by QCA/SQA in 2003. Thereafter the Nutritional Therapy Council (NTC), with support from The Prince's Foundation for Integrated Health, published the Core Curriculum and Learning Outcomes in 2004. In 2006 a grand-parenting scheme was launched for entry to the NTC voluntary register based on the HPC process; and in 2008 accreditation of courses began. In 2009 the NOS were updated by Skills for Health when the register of nutritional therapy practitioners was transferred from the NTC to the Complementary and Natural Healthcare Council. NTEC is currently updating the Core Curriculum. Both the CNHC and BANT require that nutritional therapy practitioners maintain competence and enhance capability through continuing professional development.

> 3. *The governing body must set the ethical rules and professional standards which are to be observed by the members. They should be higher than those established by the general law.*

[3] Lord Benson in a House of Lords debate on 8 July 1992. http://hansard.millbanksystems.com/lords/1992/jul/08/the-professions. We appreciate that these are not legal criteria, but nevertheless are accepted as being the general test to determine whether a profession exists.

The BANT Professional Practice Handbook provides guidance on principles of personal and professional conduct and performance, and advice on the practice of nutritional therapy. It includes guidance on the expectations of the public and clients, and sections on law, consent, advertising and dealing with complaints. A copy of BANT's Professional Practice Handbook is attached at Appendix A.

> 4. *The rules and standards enforced by the governing body should be designed for the benefit of the public and not for the private advantage of the members.*

Practitioners are subject to the CNHC Code of Conduct, Performance and Ethics and the guidance set out in the BANT Professional Practice Handbook.

> 5. *The governing body must take disciplinary action including, if necessary, expulsion from membership should the rules and standards it lays down not be observed or should a member be guilty of bad professional work.*

Fitness to practise adjudications are the remit of the CNHC who maintain the national register. BANT membership is contingent on the practitioner's registration with the CNHC. Additionally BANT has its own Professional Practice Committee which acts on complaints or other issues where fitness to practise adjudication is not applicable. BANT's Professional Practice Handbook has evolved over the last decade following feedback/complaints which have come to the Professional Practice Committee.

> 6. *Work is often reserved to a profession by statute - not for the advantage of the members but because, for the protection of the public, it should be carried out only by persons with the requisite training, standards and disciplines.*

BANT agrees entirely. This is a fundamental reason why we consider it is necessary to expand the register for dietitians to include nutritional therapy practitioners with the requisite training, standards and disciplines. Otherwise, there is a risk that dietitians will use their status as regulated professionals to practise in areas of nutritional therapy for which they might lack the relevant training and qualifications. The HCPC has had experience of a high-profile Fitness to Practice case where the dietitian in question used herbal products and dietary supplements (*K Peck* (2009) (the "Peck Case")).

> 7. *The governing body must satisfy itself that there is fair and open competition in the practice of the profession so that the public are not at risk of being exploited. It follows that members in practice must give information to the public about their experience, competence, capacity to do the work and the fees payable.*

BANT also agrees with this approach. However, for the reasons stated under 6 above, the current market environment is such that registered dietitians have a competitive advantage in that they are able to practice in the specialist area of nutritional therapy as "registered dietitians". Not only is this confusing and potentially unsafe for service users, but it distorts the market significantly as only professionals subject to statutory regulation are: 1) recognised by national government agencies and the EU as "health professionals"; 2) can provide services that are VAT exempt; 3) [in the near future] able to provide unlicensed herbal products; and 4) able to benefit from some employer professional indemnity insurances.

> 8. *The members of the profession, whether in practice or in employment, must be independent in thought and outlook. They must be willing to speak their minds*

without fear or favour. They must not allow themselves to be put under the control or dominance of any person or organisation which could impair that independence.

One of the reasons that nutritional therapy exists separate from dietetics is that very independent thought and outlook of practitioners in assessing scientific evidence and practice-based evidence. Nutritional therapy is process-based, underpinned by a set of fundamental principles and set in a practice framework which accommodates critical appraisal by practitioners. See Section 3 below.

9. *In its specific field of learning a profession must give leadership to the public it serves.*

As stated in 1 above, the primary function of BANT is to assist its members in attaining the highest standards of integrity, knowledge, competence and professional practice. BANT provides leadership in this regard not just by publishing and distributing educational material, but also by interacting with public bodies in promoting nutritional therapy. In 2002 members of BANT gave evidence to the Human Genetics Commission as part of the *'Genes Direct'* inquiry into the marketing of genetic tests direct to the public, with particular reference to nutrigenetic testing. BANT has also submitted written evidence to a number of parliamentary inquiries:

- 2008 House of Lords Science & Technology Committee inquiry into Genomic Medicine
- 2010 House of Lords Science & Technology Committee inquiry into Behaviour Change
- 2011 House of Commons Health Select Committee inquiry into Education, Training and Workforce Planning
- 2012 House of Lords Science & Technology Committee inquiry into Sports and Exercise Medicine
- 2010 the National Osteoporosis Society asked BANT to provide briefing for the All Party Parliamentary Osteoporosis Group (APPOG) inquiry into the role of nutrition in preventing osteoporosis and promoting good bone health.

All the submissions can be accessed by the BANT website at: http://bant.org.uk/centre-of-excellence/submissions-and-responses/

2.3 Affiliated Societies

In the first six months of 2014 BANT has become affiliated with 2 societies representing multi-disciplinary academic, scientific and healthcare practitioner communities: the European Society of Lifestyle Medicine ("ESLM") and the International Society of Nutrigenetics and Nutrigenomics ("ISNN"). ESLM has as its members physicians, nurses, public health, nutrition and social science experts. Upon signing the agreement between BANT and the ESLM, the Society's President noted that the affiliation with BANT was key for the achievement of the Society's goal of providing leadership in research, prevention and treatment of lifestyle-related diseases through nutrition, physical activity, psychology and public health.

BANT's role in this partnership is to provide professional support in developing guidelines, standards and policies that promote optimal patient care and health. ESLM has invited BANT to co-own a peer reviewed Journal of Lifestyle Medicine, currently being developed by scientific publisher Elsevier.

Secondly, BANT's affiliation with the ISNN is to establish a platform for communication among interested scientists and practitioners working in several disciplines (including nutrition, genetics, cellular and molecular biology, physiology, pathology, biochemistry, clinical medicine, and public health) studying the role of genetic variation and dietary response and the role of nutrients in gene expression. BANT is currently negotiating with the Society's scientific publisher Karger its co-ownership of the peer-reviewed Journal of Nutrigenetics and Nutrigenomics, which would be retitled as "*Journal of Nutrigenetics, Nutrigenomics and Individualised Nutrition*". Negotiations are ongoing with views to launching early 2015. The ISNN's President stated that BANT's understanding of genetic and biochemical individuality made it the perfect partner Society.

3. SIMILARITIES BETWEEN NUTRITIONAL THERAPISTS AND DIETITIANS

Nutritional therapy practitioners meet all the HCPC Standards of Proficiency for Dietitians (2013) except for those that relate to acute nutrition and withholding/withdrawal of nutrition. This area of practice is confined to the NHS setting and therefore outside the nutritional therapy scope. Neither is acute (parenteral/enteral) nutrition discrete dietetic practice since critical care nurses, gastroenterologists and others also participate.

BANT therefore submits that the acute scope of practice is a specialist area of practice and should not be a registration pre-requisite. In support of this view, BANT would highlight:

- In 2012 the British Dietetic Association formed 'Dietitians in Critical Care' (DCC) "*following a need identified among dietitian's working in the area of critical care for a specialist group which purely focused on critical care*" ... Patients in intensive care are critically ill and have complex nutritional needs due to the severity of their illness or injuries. The dietitians working within intensive care units need to acquire specific knowledge and develop skills, so they can best manage the nutritional needs of all critically ill patients."[4]

- The 2009 European Dietetic Competencies published by the European Federation of the Associations of Dietitians[5] sets out competencies in General Dietetics as "*the basis for all Dietitians at the point of qualification and in all working environments*" and then additionally for those specific to those working in Clinical, Administrative or Public Health Dietetics. In terms of acute nutrition, the performance indicators are that the dietitian 'participates' in the determination of appropriate formula and feeding route for clients, suggesting that this is not an autonomous scope of practice. Again, nutritional therapy practitioners meet all the generic competencies except for those relating to acute care.

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[4] https://www.bda.uk.com/regionsgroups/groups/criticalcare/home

[5] http://www.efad.org/everyone/1468/5/0/32

- BAPEN (British Parenteral and Enteral Nutrition Society) comprises membership of the following core groups:
    - Dietitians – The Parenteral & Enteral Nutrition Group of the British Dietetic Association (PENG)
    - Doctors & Scientists
        - BAPEN Medical
        - The British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN)
    - Nurses – National Nurses Nutrition Group (NNNG)
    - Patients – Patients on Intravenous and Nasogastric Nutrition Therapy (PINNT)
    - Pharmacists – British Pharmaceutical Nutrition Group (BPNG)

But for the requirement for a placement in the NHS as part of an HCPC approved course, one group of practitioners is regulated by statute and obtains the benefits associated with that (recognition as a 'health professional', provision of VAT exempt services, automatic indemnity cover for all employment situations) whereas nutritional therapy practitioners are excluded.

The Nutritional Therapy National Occupational Standards and the NTEC Core Curriculum and Learning Outcomes are attached at Appendix B and C.

4. THE DIFFERENCES BETWEEN NUTRITIONAL THERAPISTS AND DIETITIANS

As described above, there is significant overlap between the practice of nutritional therapy and dietetic practice, but there are also fundamental differences. It is first necessary to explain the background to diet and health and also dietary regulation.

4.1 Diet and Health: Historical Differences

Over the last 50 years the influence of diet on health generally, and in particular in relation to chronic conditions which are associated with ageing and overweight/obesity has been the subject of significant interest and debate. In 2000 the House of Lords Science and Technology Committee, in its report on Complementary and Alternative Medicine, characterised 'nutritional medicine' as:

> *"Term used to cover the use of nutritional methods to address and prevent disease. Uses diets and nutritional supplements. Often used to address allergies and chronic digestive problems. The difference between nutritional medicine and dietetics is that nutritional therapists work independently in accordance with naturopathic principles and focus on disorders which they believe can be attributed to nutritional deficiency, food intolerance or toxic overload. They believe these three factors are involved in a wide range of health problems. Dietitians usually work under medical supervision, using diets to encourage healthy eating and tackle a narrower range of diseases.*

Nutritional therapists often use exclusion diets and herbal remedies to tackle patients' problems."[6]

This House of Lords definition is useful in that it makes absolutely clear that nutritional therapy practitioners often use herbal preparations, amongst other things. However, it does not cover the full range of therapy services that nutritional therapy practitioners provide and that are distinct from dietetics, including nutrigenetics.

Following the House of Lords report, there was increasing awareness of the evidence of diet and its effect on health. For example, the EU-funded PASSCLAIM project,[7] which ran from 2001-2005, was set against the context that:

> *"the primary role of diet is to provide sufficient nutrients to meet the metabolic requirements of an individual and to give the consumer a feeling of satisfaction and well-being through hedonistic attributes (such as taste). In addition, by modulating specific physiological targets, diet can have an additional function: beneficial physiological and psychological effects beyond the widely accepted nutritional effects. In fact, diet can not only help to achieve optimal health and development, but it does also play an important role in reducing the risk of disease."*

The key areas included: cardiovascular disease; bone health and osteoporosis; physical performance and fitness; body weight regulation, insulin sensitivity and diabetes risk; diet-related cancer; mental state and performance; and gut health and immunity. These areas correlated with the wider scope of practice identified in the House of Lords nutritional therapy descriptor as distinct from traditional dietetic practice within the NHS, and for which patients are referred to dietitians.

4.2 Background to Dietary Regulation

While dietetics is the application of knowledge of diet and nutrition in relation to individual health, it has in effect only been that area of practice relevant to work in the National Health Service which determined statutory registration rather than the full domain of nutrition and health practice. In 2014, the work of dietitians is characterised on the website of the British Dietetics Association as:

> *"Dietitians are the only qualified health professionals that assess, diagnose and treat dietary and nutritional problems at an individual and wider public-health level. They work with both healthy and sick people. Uniquely, dietitians use the most up-to-date public health and scientific research on food, health and disease which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.*
>
> *Dietitians are the only nutrition professionals to be regulated by law, and are governed by an ethical code to ensure that they always work to the highest standard. Dietitians work in the NHS, private practice, industry, education, research, sport, media, public relations, publishing, government and Non-Government Organisations (NGOs).*

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[6] http://www.publications.parliament.uk/pa/ld199900/ldselect/ldsctech/123/12304.htm#a15

[7] http://www.ilsi.org/Europe/Pages/PASSCLAIM.aspx

Dietitians advise and influence food and health policy across the spectrum from government, to local communities and individuals."[8]

On the HCPC website the work of a dietitian is defined as:

"A dietitian uses the science of nutrition to devise eating plans for patients to treat medical conditions. They promote good health by helping to facilitate a positive change in food choices. "[9]

From the 1951 Cope Report, through the Hansard debates in 1959 and the passing of the 1960 Professions Supplementary to Medicine Act until the establishment of the Health Professions Council in 2002, the statutory register of dietitians has been of a profession whose work is in the ambit of the dietary treatment of medical conditions. Dietitian students must obtain experience in an NHS hospital before they can graduate and register with the HCPC. However, experience within the NHS is not a legal requirement and is, in our view, relevant only for those practitioners who wish to practice in acute dietary care. This requirement does not reflect the modern scope of practice of dietetics or requirement of nutrition and health professionals working outside the NHS.

4.3 Herbal Practitioners

All nutritional therapy practitioners use herbs and comprise a significant proportion of herbal practitioners in the UK. However, unlike medical herbalists, competencies do not include the cultivation and preparation of herbal products but merely prescribing of third-party products. Directive 2004/24/EC of the European Parliament and of the Council of 31 March 2004 defines herbal medicinal product as:

> "*Herbal medicine product....substances in combination with one or more such herbal preparations;*
>
> *31. Herbal substances: All mainly whole, fragmented or cut plants, plant parts, algae, fungi, lichen in an unprocessed, usually dried, form, but sometimes fresh. Certain exudates that have not been subjected to a specific treatment are also considered to be herbal substances. Herbal substances are precisely defined by the plant part used and the botanical name according to the binomial system (genus, species, variety and author);*
>
> *32. Herbal preparations: preparations obtained by subjecting herbal substances to treatments such as extraction, distillation, expression, fractionation, purification, concentration or fermentation. These include comminuted or powdered herbal substances, tinctures, extracts, essential oils, expressed juices and processed exudates.*"

[8] https://www.bda.uk.com/improvinghealth/yourhealth/dietitians

[9] http://www.hcpc-uk.org/aboutregistration/professions/

BANT considers that a number of dietitians in private practice use herbs and dietary supplements in the same manner as nutritional therapy practitioners but without appropriate training in their use under current dietetic standards. This specific issue came to the HCPC's attention in the Peck case discussed above. The Peck case was widely reported in the media. What constitutes herbal medicine, however, is not fully characterised as the food/medicine boundary has long been opaque with responsibility for medicines and food regulation coming under different European Commission directorates. The European Medicines Agency's ("EMA") database of herbal substances includes *inter alia* sage, thyme, garlic, onion, cinnamon, pumpkin seed, linseed, juniper berry, peppermint leaf, aniseed. The UK's Medicines and Healthcare Products Regulatory Agency ("MHRA") publishes its own list of herbs and classifies them as medicine/food/cosmetic but does not publish the criteria on which it makes the classification. Nutritional therapy practitioners do, however, commonly use herbs that are on the MHRA medicinal list.

The newly revised, June 2014, edition of the BDA Manual of Dietetic Practice includes a section (4.1) on Freelance Dietetics which maps career pathways outside the NHS. There are also guarded references in clinical dietetic practice chapters to *inter alia* Saw Palmetto, Devil's Claw, Ginseng, Agnus Castus reflecting their professional creep into herbal practice.

4.4 Nutrigenomics and Nutrigenetics

One of the key historical differences in nutritional therapy and dietetic practice has been that nutritional therapy practitioners have recognised the individual nature of the nutritional response beyond avoiding classic diseases of nutrient deficiency (e.g. rickets, pellagra).

BANT's definition of "nutrition and health" is:

> *"Nutrients and other food components influence the function of the body, protect against disease, restore health, and determine people's response to changes in the environment. Under certain circumstances and in some individuals, diet can be a serious risk factor for a number of diseases. Common dietary chemicals can act on the human genome, either directly or indirectly, to alter gene expression or structure. The degree to which diet influences the balance between healthy and disease states may depend on an individual's genetic makeup. Dietary intervention based on knowledge of nutritional requirement, nutritional status, and genotype (i.e., "personalized nutrition") can be used to prevent, mitigate or cure chronic disease."*[10]

BANT has established a register of Nutrigenetic Counsellors, which is a first stage register of those nutritional therapy practitioners who use genetic data. Draft competencies on nutrigenetic counselling will be the subject of a consultation during 2014/15 and will then be available as standards for education and training and ultimately for direct entry to the register. This scope of practice is uniquely that of the nutritional therapy practitioner. Dietitians to date only deal with patients suffering from the inborn errors of metabolism, which are single gene disorders identified in the early 20th century, e.g. phenylketonuria.

Nutrigenomics is the science which looks at the effect of diet and dietary chemicals on the genome. Nutrigenetics characterises gene variants which dictate response to and requirements

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[10] http://bant.org.uk/about-nutritional-therapy: references: (1) Vorster HH Introduction to Human Nutrition. 2nd Edition. Nutrition Society; and (2) Kaput J & Rodriguez RL (2004) Nutritional genomics: the next frontier in the postgenomic era. Physiological Genomics 16 1666-177

from diet. Post-genome nutrition science has challenged the one-size-fits all 'public health nutrition' paradigm. In 2002 Artemis Simopoulos of the Centre for Genetics, Nutrition and Health in Washington DC said *"there may be no such thing as a 'normal' population with respect to nutrient requirements, as was assumed when dietary reference values were established............populations should not copy each other's dietary recommendations for the prevention of coronary artery disease, and cancer, or any other disease for that matter".*[11] In November 2006 in Washington DC at a workshop organised by the US Institute of Medicine, the IOM President Fineberg spoke about the challenge facing the public health paradigm: *"...It is not just possible but likely that there are nutrients that affect some population groups differently than others, and public health guidelines will have to take such differences into account...A public health paradigm of universal education is going to have to be adapted to the scientific reality and scientific knowledge as it develops and unfolds".*[12] In 2007 the UK Committee on Toxicity, in its report on Variability and Uncertainty in Toxicology, stated that for vitamins and minerals "*variability in the response of individuals has the potential to result in a situation which a given level of exposure could be essential for some but toxic for others*".[13]

Scientists in the US and Australia have published on variation and micronutrient intake based on the premise that optimal levels are those that minimise DNA damage and mitochondrial decay, which may vary considerably between individuals (Ames *et al.*, 2002; Ames, 2003; Fenech, 2005).[14,15,16]

The extent of variability in the nutritional response to and requirement from diet is a direct challenge to the universal public health approach to nutrition.

4.5 Why do nutritional therapy practitioners exist?

Why are dietitians not already practising nutritional therapy if it is science-based and evidence-based? Nutritional therapy has developed over the last 25 years without the constraints of NHS practice or the competing public health one-size-fits-all paradigm where national dietary guidelines are adopted in clinical practice and 'evidence-based nutrition' is showcased as the (current) EatWell Plate, 5 a day guidance and population reference nutrient intakes. The divergence, or evolutionary bifurcation point, came in the 1960s when Nobel Laureate Linus Pauling put forward the idea of 'optimum nutrition' where a level of health could be obtained when some micronutrients were consumed in excess of that which had been determined for growth, maintenance and repair. Pauling's particular interest was in psychiatry and mental disease being alleviated by using nutrient substances which he labelled as 'orthomolecular' in

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[11] Simopoulos AP (2002) Genetic variation and dietary response: Nutrigenetics/nutrigenomics. *Asia Pacific Journal of Clinical Nutrition* **11**, 117-128

[12] http://www.nap.edu/openbook.php?record_id=11845

[13] http://cot.food.gov.uk/cotwg/wgvut/

[14] Ames BN (2003) The metabolic tune-up: metabolic harmony and disease prevention. *Journal of Nutrition* **133**, 1544S-1548S.

[15] Ames BN, Elson-Schwab I & Silver EA (2002) High-dose vitamin therapy stimulates variant enzymes with decreased coenzyme binding affinity (increased K(m)): relevance to genetic disease and polymorphisms. *American Journal of Clinical Nutrition* **75**, 616-658.

[16] Fenech M (2005) The Genome Health Clinic and Genome Health Nutrigenomics concepts: diagnosis and nutritional treatment of genome and epigenome damage on an individual basis. *Mutagenesis* **20**, 255-269.

his landmark paper published in *Science* in 1968.[17] Pauling hypothesised that *"optimum molecular concentrations of substances normally present in the body may be different from the concentrations provided by the diet and the gene controlled synthetic mechanism, and, for essential nutrilites (vitamins, essential amino acids, essential fatty acids) different from the minimum daily amounts required for life or the recommended (average) daily amounts suggested for good health."* Pauling used examples from evolution and natural selection (ability of some mammals to synthesise ascorbic acid), from microbial genetics (pyridoxine-requiring mutant of Neurospora sitophila) and variations in the catalysing capacity of some mutant enzymes, work which was later taken forward by Bruce Ames [referenced above]. Pauling's hypothesis and proposal for megavitamin therapy was roundly rebuffed by the general scientific community and this branch of nutrition practice has built during the last forty years under the label of 'complementary and alternative medicine'. Post-genome nutrition science now recognises Pauling's insight and the extent of variability.

Today nutritional therapy comprises individualised dietary, supplement and lifestyle advice within a Functional Medicine framework to promote optimal physical and mental well-being. It is science-based and grounded in the following principles:

- Biochemical individuality: understanding and appreciating the importance of variations in metabolic function deriving from genetic, epigenetic and environmental differences among individuals.

- Patient-centred: emphasising "patient care" rather than "disease care," following Sir William Osler's admonition that "*It is more important to know what patient has the disease than to know what disease the patient has.*"

- Dynamic balance of internal and external factors: understanding that resilient homeostasis (the buffering capacity to respond to a perturbation) is important for physiological equilibrium.

- Web-like interconnections: human physiology functions as an orchestrated network of interconnected systems, rather than individual systems functioning autonomously and without effect on each other.

- Health as a positive vitality and not merely the absence of disease.

- Promotion of organ reserve as the means to enhance health span by maintaining genomic stability and mitochondrial capacity so decreasing morbidity.

It is a truly holistic model capable of adapting to meet individual and organisational requirements in modern healthcare.

This model has now been adopted as a specialist practice area for dietitians in the United States:[18]

[17] Pauling L (1968) Orthomolecular psychiatry. Varying the concentrations of substances normally present in the human body may control mental disease. *Science* **160**, 265-271

[18] http://www.integrativerd.org/

"Dietitians in Integrative and Functional Medicine (DIFM) Academy of Nutrition and Dietetics Practice Group #18

The Dietitians in Integrative and Functional Medicine (DIFM), a practice group of the Academy of Nutrition and Dietetics, consists of 3,400+ Registered Dietitian Nutritionists (RDNs), Dietetic Technicians, Registered (DTRs), and dietetic students and interns who practice in, or have specific interest in, an integrated and personalized approach to nutrition, health, and healing. The DIFM philosophy centers around a holistic, "Food as Medicine" approach to wellness, and is based firmly in the Integrative Medicine model. Whole-food therapies, targeted supplements, and mind-body modalities form the basis of "Integrative and Functional Medical Nutrition Therapy" (IFMNT). Integrative Nutrition RDNs apply this model to the nutrition care process in clinical practice and are also instrumental in reshaping healthcare."

4.6 Evidence-based Practice

The 2014 Manual of Dietetic Practice (page 12) contains a definition of evidence-based practice which nutritional therapy practice also recognises. Building on Sacket *et al* [19] the International Confederation of Dietetic Associations defines evidence-based dietetics practice as being '*...about asking questions, systematically finding research evidence, and assessing the validity, applicability and importance of that evidence. This evidence-based information is then combined with the dietitian's expertise and judgement and the client's or community's unique values and circumstances to guide decision-making in dietetics.*' BANT wholly endorses this definition and believes that now is the time for dietetics and nutritional therapy regulation and practice to move together for the benefit of both the public and the profession.

5. THE NEED FOR MODIFICATION OF THE STATUTORY REGISTER

The legal test for determining whether a modification to a statutory register is set out under section 60(1)(a) of the Health Act 1999. This provides that modifications to the register may be made if it "*appears... to be **necessary or expedient** for the purpose of **securing or improving the regulation of the profession** or **the services which the profession provides or** to which it **contributes**.*" (Emphasis added).

The legal test is satisfied, therefore, if it is necessary or expedient. However, we consider that it is both necessary **and** expedient and we explain why below.

5.1 Necessary or expedient

Modification of the register is *necessary* for securing the improvement of the profession and the services it provides for the following key reasons:

[19] The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. Sacket DL, Rosenberg WMC, Gray JAM and Richardson WS (1996). Evidence based medicine: what it is and what it isn't. British Medical Journal. 312 (13 January 71-72)

- There is significant patient and professional confusion about the differences between dietitians and nutritional therapists. In December 2001 the Associate Parliamentary Food and Health Forum arranged a discussion of the differences between Dietitians and Nutritionists. In December 2003 the Department of Health approved funding for the Nutrition Society to conduct research into the confused situation recognising *"how complex the situation is, with overlapping roles, titles ...and the need to protect the public and professionals alike."* In 2004 the Nutrition Society published its report *'Understanding the Differences between Nutrition Health Professionals'.* This report then led to the report on Mapping the Workforce [see below].

- Dietitians are practising in areas outside their professional competency, including administering herbal preparations (see for example the Peck case). This undermines the professional and puts patient safety at risk. The specific need for statutory regulation of herbal practitioners was recognized by the Secretary of State for Health as being compelling and one that voluntary registration cannot account for. As such, he has already announced the intention to create a register for this group but as yet one has not been established.[20]

- Modification is necessary to ensure that fundamental rights of nutritional therapy practitioners are respected, including the rights of equality, non-discrimination and competition in the practice of nutrition whilst ensuring that high standards of consumer protection are maintained. These include recognition as health professionals, ability to provide VAT exempt services, right to inclusion in group insurance covers, ability to work within the NHS and some private service providers.

For the reasons above, it is also *expedient* for nutritional therapists to be regulated under a single statutory register for nutrition. Indeed, in January 2006 the Nutrition Society published its report funded by the Department of Health on 'Nutrition Capacity in the United Kingdom: Mapping the Primary Nutrition Workforce'. This report anticipated some merging of professions:

> *"In the* ***longer term****, the research indicates a need to consider the possibility of having just one, regulated professional group speaking for nutrition. One possibility suggested was through the Health Professions Council,* ***by expanding the Dietetics to encompass Dietetics and Nutrition, and including anyone (including nutrition therapists) who meet the HPC criteria.*** *"*[21] (Emphasis added).

In terms of precedent, this wider scope of practice is recognised in the United States, where the American Dietetic Association now has a section for "*Functional Medicine Dietitians*".[22]

Nutritional therapy practitioners submit that they may therefore be classed as 'Functional Medicine Dietitians'.

6. CONCLUSION

[20] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf

[21] Section 14, http://www.nutritionsociety.org/documents/20060629fulldefiningnutritionreportforcouncil.pdf

[22] http://www.integrativerd.org/

Nutritional therapy and dietetic practice are inextricably linked. But there are key differences that have caused significant confusion and put patients at risk. Modifying the dietitian's register to cover nutritional therapy would therefore serve a number of purposes.

- First, it would bring nutritional professionals under the scope of a single, statutory register. A single register for nutrition covering both dietitians and nutritional therapy practitioners is both necessary and expedient for the purpose of securing and improving the regulation of the profession and the services that the profession provide. In particular, there is a compelling case that regulation would remove patient confusion and ensure patient safety by raising standards within the profession. As such, it meets the legal test for the modification of a register pursuant to Article 60(1)(a) of the Health Act 1999.

- Second, it would meet in large part the Secretary of State's objective to regulate herbal practitioners given that nutritional therapy practitioners administer herbal preparations. This is therefore a proportionate and cost-effective means of achieving that objective.

- Third, it would meet the objective of the Human Genetics Commission, stated in their 2003 'Genes Direct' report, that practitioners using genetic tests should operate under standards as stringent as those for doctors, nurses and pharmacists.

- Fourth, a single statutory regulator is consistent with fundamental principles of fairness, equality, non-discrimination and competition in the practice of nutrition whilst ensuring that high standards of consumer protection are maintained.

We respectfully request that you modify the register accordingly. BANT remains at your disposal to facilitate and support the necessary changes.

7. APPENDICES

A - BANT PROFESSIONAL PRACTICE HANDBOOK

B - THE NUTRITIONAL THERAPY NATIONAL OCCUPATIONAL STANDARDS

C - THE NUTRITIONAL THERAPY EDUCATION COMMISSION CORE CURRICULUM AND LEARNING OUTCOMES

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BANT Professional Practice Handbook

Version 2.2

Authors:

BANT Professional Practice Committee (PPC)

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Section 1 – The Handbook

1.1 Purpose of the Handbook

This handbook provides guidance and advice on the practice of nutritional therapy and the principles of personal professional conduct and performance. It includes guidance on the expectations of the public and clients.

It is an evolving document and will be updated as and when changes occur within BANT or the Nutritional Therapy profession.

You are also encouraged to read the FAQ section of the BANT website, which discusses common questions that arise as to the interpretation of the information contained within this handbook – www.bant.org.uk/members-area/professional-practice/frequently-asked-questions-of-the-ppc/

The standards set out in this document apply to all members of BANT, regardless of their employment status (whether working as a private practitioner, in a partnership or as an associate, employee or locum) and their working environment (whether in the local community, in a multi-disciplinary practice or in public health).

All BANT members are personally accountable for their professional activity and must be able to explain and justify each and all of their decisions. They must also act safely and lawfully at all times.

BANT seeks to protect the public by developing and promoting the nutritional therapy profession. As part of that duty, BANT has adopted the CNHC Code of Conduct, Performance and Ethics which lays down the standards of conduct and practice expected of members of BANT, and this is a public document.

All BANT members should familiarise themselves with and follow the CNHC Code - www.cnhc.org.uk/index.cfm?page_id=91

The BANT Professional Practice Handbook is the property of BANT and its members, and the contents are intended to support, benefit and protect both the BANT Practitioner and his or her client.

Any misuse, printing or copying of this document is strictly prohibited.

Copies must not be given to non-members – it is for internal use only.

1.2. Purpose of Handbook and Code of Conduct

Membership of BANT must be regarded as an assurance to clients, the medical profession, other healthcare professionals and the general public, of the BANT practitioner's professional competence and integrity.

BANT fully supports and recommends that all nutrition professionals involved in providing advice to the public should come under the strictest regulation and from 2014 all members have to be registered with the Complementary and Natural Healthcare Council (CNHC). BANT members also agree to abide by the BANT Handbook of Professional Practice (this document), which is designed to ensure that members of the public receive a consistent, professional and safe experience when visiting a qualified BANT practitioner member.

The member has the right to belong to other organisations whose ethical standards may differ from those of BANT. Such dual membership does not give the member immunity from the consequences of contravening the CNHC Code of Conduct, Performance and Ethics and the BANT Professional Practice Handbook.

1.3 The Role of the Nutritional Therapist (NT)

You can find the official definition of Nutritional Therapy and the role of the Nutritional Therapist on the BANT website at the following link:
www.bant.org.uk/about-nutritional-therapy/why-use-nutritional-therapy/

In addition to this, the activities of a nutritional therapist may include:

- liaison with and appropriate referral to other health professionals;
- education of the public, media and other health professionals on the importance of nutrition for human health through presentations, the provision of literature, use of media such as radio and TV;
- undertaking postgraduate research, Masters degrees and PhDs to further develop the field of nutritional therapy;
- performing clinical audits and disseminating findings through appropriate reports and publications;
- contributing to academic journals through writing articles, reports and case studies;
- teaching nutritional therapy in primary, secondary and tertiary educational establishments;
- training health food traders and other groups in industry;
- updating professional knowledge through continuing professional development (CPD);
- providing technical support in industrial settings.

The role of a BANT nutritional therapist does not include:

- The practice of other non-nutritional modalities
- The retail of supplements or services to the general public outside of an individual consulting relationship. See section 2.5 (f).

If you are involved in any of these activities, it must be made clear that they fall outside the scope of BANT and the BANT logo may not be used on any promotional material for these activities.

These are binding requirements. Members must also comply with all related legislation in the country in which they are practising, and it is their responsibility to make themselves aware of this legislation.

1.4 The Professional Practice Committee

The Professional Practice Committee (PPC) sets standards (as set out in the CNHC Code of Conduct, Performance and Ethics www.cnhc.org.uk/index.cfm?page_id=91 and the BANT Professional Practice Handbook (www.bant.org.uk/wp-content/uploads/2013/12/BANT_PROFESSIONAL_PRACTICE_HANDBOOK.pdf) for professional practice and monitors their implementation by practitioners.

The PPC is charged by BANT Council with maintaining a clear focus on all aspects of professional practice, including essential linkages with BANT's other core objectives related to training, education and research.

The PPC has the following key roles:

1) To investigate complaints against a BANT member by another BANT member but only where the complaint relates to the member's professional practice in their work with clients or other activities associated with applied nutrition (e.g. teaching, supervision, writing etc). – *See Section 3 – Handbook Changes - Appendix 1.*

2) To investigate complaints from members of the public against members who are registered with CNHC

3) To investigate all complaints from members of the public against BANT members who are not registered with CNHC

4) To advise members, if they are uncertain, on how to apply the CNHC Code of Conduct, Performance and Ethics and the BANT Professional Practice Handbook

You can see this remit plus the information on the Professional Practice Committee members at the following link:
www.bant.org.uk/members-area/professional-practice/professional-practice-committee-ppc/

Section 2 – Professional Practice

2.1 Contract with the client

When you see a client, you enter into a relationship where the terms must be clearly understood and accepted by both sides. It is your duty to ensure, to the best of your ability, during and after the consultation, that the client understands what you can and cannot offer.

It is your duty to take reasonable care, when using your professional knowledge and skills, in advising clients. You must also take every reasonable step to ensure that anyone assisting you at your place of work is competent to carry out the duties delegated and that they are properly trained and supervised where necessary.

BANT does encourage the use of the BANT Terms of Engagement (ToE). You can download the most recent version from the PPC section of the website.
www.bant.org.uk/wp-content/uploads/2013/12/TERMS_OF_ENGAGEMENT.pdf

The **BANT** Terms of Engagement (ToE) document is designed to be signed by both the client and practitioner member at the start of the consultation to provide mutual protection and reference throughout, and to make the remit of the consultation clear and transparent to all involved.

You may provide additional information or alter the document, however, it will not subsequently be endorsed by BANT and can therefore not carry the BANT logo. BANT encourages you to use it in its original format and provide additional information in a separate document.

It is important to remember that the Terms of Engagement:

- Relates only to the practice of Nutritional Therapy and that should the practitioner include other modalities in the consultation, he/she will need to make this clear from the outset so as not to cause any confusion.

- Is separate from any commercial agreement that you would have with your client. A commercial agreement outlines the details of how you run your business and this is where you would include issues such as data protection, fees, appointment cancellations and deposits etc. They are more generic statements and detail the services you provide or supply.

2.2 The Law

a) General guidelines

You must at all times act within the law. It is your responsibility to ensure that you understand your legal obligations and to keep up to date with any changes that may affect your practice. If you are ever in doubt take legal advice.

BANT cannot provide legal advice.

Reporting criminal activity that a BANT practitioner learns about through a therapy consultation is a decidedly tricky situation. The information shared between a client and therapist, in almost all cases, is meant to be kept confidential in order to build a trusting relationship. However, there can be exceptions to this rule. Most of these exceptions are related to the possibility of violence or violence that has already occurred.

If a client confides in a BANT practitioner that she and her children are being abused by her husband/partner or another family member it is important initially to check with the client to see if she has already informed someone and whether Social Services are involved.

If it is sexual abuse or domestic violence the BANT practitioner would need to advise his/her client to seek support from social services or the police as they have specialist teams to deal with such situations. If the BANT practitioner knows or suspects that the mother will not seek advice, this is not protecting the child or children, then the BANT practitioner has a responsibility to the child and must inform the mother that she intends to make a referral to social services.

This is clearly detailed in Children Act 1989 – www.legislation.gov.uk/ukpga/1989/41/contents and the 'paramountcy of the child' which is a principle stemming from Family Law Act 1975, in which it was stated that the best interests of the child must be regarded as the paramount consideration when making specified decisions as to the child's health and welfare.

b) Children under the age of 16

From the age of 16, children are presumed in law to be competent to give consent for themselves. You must not advise or consult with clients who are under sixteen years of age, without the written consent of their parent or guardian, and without their parent or guardian being present. BANT encourages members to use the BANT Consent to Consult a Child Form –
www.bant.org.uk/wp-content/uploads/2013/12/CONSENT_TO_CONSULT_A_CHILD.pdf

Under the Children Act 1989 the following people may have parental responsibility:

- the child's parents;

- the child's mother but not the father if they are not married, and not even if they marry later, unless the father has acquired parental responsibility by becoming registered as the child's father through either a court order or parental responsibility agreement;
- the child's legally appointed guardian;
- the person in whose favour the court has made a residence order concerning the child;
- a local authority named in a care order for a child;
- a local authority or authorised person who holds an emergency protection order for the child.

BANT practitioners should also follow the UK Government Guidelines. You can view the government guidelines in the booklet 'Seeking consent: Working with Children' at www.dh.gov.uk (publications).

The following is taken from that publication:

"Children aged 16 and 17
Once children reach the age of 16, they are presumed in law to be competent to give consent for themselves for their own surgical, medical or dental treatment, and any associated procedures, such as investigations, anaesthesia or nursing care. This means that in many respects they should be treated as adults – for example if a signature on a consent form is necessary, they can sign for themselves.

However, it is still good practice to encourage competent children to involve their families in decision-making. Where a competent child does ask you to keep their confidence, you must do so, unless you can justify disclosure on the grounds that you have reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm. You should however seek to persuade them to involve their family, unless you believe that it is not in their best interests to do so."

Please also note section B4.7 of the CNHC Code of Conduct, Ethics and Performance which states *'As with adults, consent is valid only if an appropriately informed person capable of consenting to the particular treatment gives it voluntarily. However, unlike with adults, the refusal of a competent person aged 16 to 17 may in certain circumstances be overridden by either a person with parental responsibility or a court'.*

Anyone working with children should also read and familiarise themselves with 'Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children'.
This can be downloaded at:
http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00305-2010

A parent or guardian, who fails to provide adequate medical aid for a child under the age of sixteen, commits a criminal offence. Nutritional therapy is not medical aid, as defined by the law.

If you advise a child whose parents refuse medical aid, you risk being considered to be aiding and abetting in that offence. Where you believe that parents are not providing necessary medical attention for the child, you are most strongly advised to inform the Children and Young People's Service of the social services department of your local authority, or the child protection officer of your local police force (Ref: Children Act 1989).

When working with children in a care home situation – it is necessary to have permission from the parent to work with the child. The parent must attend the consultations and it is advisable for the care worker to also attend. You will need to obtain permission from the parent to have ongoing communication with the care worker. This also applies to working with adults in care homes.

c) Vulnerable children and adults

You have a duty under the law to safeguard the welfare of children and vulnerable adults if you work with them. If you have any concerns which cannot be discussed with a colleague or other agencies, you should contact your local social services department.

You should also contact social services if you consider a person or vulnerable adult to be at risk.

In general, however, you should try to discuss your concerns with the child or vulnerable adult as far as their age or understanding allows, or with their parents or guardian.

Aim to obtain agreement, from the person or child in question, to make a referral to social services unless you consider such discussion would place the child or you or your practice staff at risk of significant harm.

d) Titles

If you are a member of any other professional organisation, you may use any relevant title or qualification, provided that the title or those qualifications are not in any way used to mislead the public.

You may not falsely use the title 'doctor' or 'dietician' directly or indirectly in such a way as to imply that you are a registered medical practitioner or state registered dietician. Examples of direct use would be publicly using the title or simply referring to yourself as a doctor or dietician. An example of indirect use would be to permit another person to refer to you as a doctor or dietician without correcting that person.

e) Other professions

You may not attend a woman in childbirth, or attend for reward ten days thereafter, unless you are a registered midwife or registered nurse qualified to practise midwifery.
The Veterinary Surgeons Act 1966 prohibits anyone, other than a qualified veterinary surgeon, from consulting with animals; including diagnosing ailments and giving advice based upon such diagnosis.

2.3 Practitioner Conduct

a) Consultation and Advice

Prior to a consultation you must take care to explain fully the general procedures involved, including issues such as:

- Questionnaires
- Fees
- Likely content and length of consultation
- Number of consultations
- Functional tests and Supplements
- Payment and cancellation policy

The first appointment, with a client, should be a face-to-face consultation. Further personal contact, either face-to-face or by telephone or Skype etc., should be made at appropriate intervals with a client to ensure continuity of care. The use of Skype/other forms of electronic communication, including the use of webcam, do not currently constitute a face-to-face consultation.

If, for any reason, an initial face-to-face consultation is not practical, a telephone or Skype consultation may be conducted and must be accompanied by thorough case taking and client questionnaire. If this is the case, the following guidelines must be followed before a telephone/Skype consultation takes place:

i. The client must be advised on initial contact that a 'face to face' consultation is a preferable form of consultation.

ii. The client should be given the details of the practitioner directory on the BANT website to allow them to try to find a practitioner in their local area to enable a 'face to face' consultation to take place.

iii. Notes must be made in the client's file as to the reason for not holding an initial 'face to face' consultation (e.g. invalidity or ill health, distance from any available practitioner, personal choice of client, client lives abroad etc.)

Other forms of communication

Wherever possible, at some point in the therapeutic relationship, the practitioner should make a visit to the client or ask them to visit for a face-to-face appointment.
If using Skype /Telephone you must ensure that you are not overheard so that the consultation is confidential.

Text messaging should only be used for administrative information such as confirming an appointment or informing a client that you are running late for an appointment. No nutritional advice should be given within a text message. Where possible, the contents of text message should be printed and filed in the client's file.

When using emails you should remember that these need to be filed like any other communications in the client's file.

Forms of social media such as Twitter and Facebook , etc. are not at this point in time considered a suitable method of communication for consultations, and not deemed professional for consultations with a client.

b) Professional Standards

You must be polite, respectful and considerate to all your clients. You must at all times conduct yourself in an honourable and courteous manner and with due diligence in your relations with your clients, the public, other health professionals and with other members of BANT.

As a BANT member you must abide by the CNHC Code of Conduct, Performance and Ethics and the information contained in the BANT Professional Practice Handbook.

You should maintain a professional standard at all times and conduct yourself at all times in a manner that does not bring BANT into disrepute. If you are unclear of any aspect of the CNHC Code you should initially consult the PPC. www.cnhc.org.uk/index.cfm?page_id=91

c) Maintain respect for the client's right to be involved in decisions about their healthcare

You must share with your clients the information they want or need, to make decisions about their health and wellbeing, and related care options.

The information normally shared with the client would include:

- nutritional health issues (e.g. observations from history taking, information regarding how symptoms relate to nutrition etc.)

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- information on functional testing and supplements
- reasons for referring back to GP
- reasons for referrals to other healthcare professionals
- right of the client to undertake a second opinion
- financial implications of the recommended support
- information on the likely number of consultations and the duration of any supplement plan recommended.

d) Justify public trust and confidence

- You must justify public trust and confidence by being honest and trustworthy.
- You must never promise cure or recovery.
- You are not allowed to treat or diagnose medical conditions
- You must not advise a client in any case which exceeds your capacity or competence. In such cases, you should call in another nutritional therapist or refer the client to another appropriate practitioner or a registered medical practitioner.
- You must not create any fear, through disclosing your unjustified views to a client.

e) Effective communication

Establish effective communication with your client by listening to and acknowledging their views:

- Listen to your client's concerns
- Ask for and respect their views
- Encourage them to ask questions
- Answer any questions as fully and honestly as possible
- Check that the client has understood everything
- Ask if they want more information before making any decision

f) Avoid conflicts of interest

To avoid conflicts of interest, you must not ask for, or accept, any inducement, gift or hospitality which may affect or be seen to affect the way you advise or refer clients.

You must not abuse your position of trust, such as, by using undue influence to gain financial benefit from a client, or use professional visits to a client's home, or knowledge gained in professional confidence, to pursue a personal relationship either with the client or a member of their family.

It is unacceptable to solicit business with potential clients; it is however acceptable to explain the meaning and relevance of nutritional therapy and nutrition education where this is appropriate; for example if you are asked, or if there is an obvious opening for such information to be given during the course of a conversation.

You must avoid undermining public confidence through arguments between you and members of other healthcare professionals concerning a particular client. This includes soliciting the clients of other healthcare professions.

g) Keep up to date with CPD

Provision of a high standard of practice and care includes commitment to continuing professional development (CPD) in order to keep up to date with the latest developments in nutritional therapy.

BANT CPD is now mandatory for all full members, including non-practising members, and all CPD will need to be entered onto the online BANT CPD logging system.

All members should achieve the mandatory minimum of 30 hours of CPD annually – of which a minimum of these should be 8 hours of Active CPD.
www.bant.org.uk/members-area/continued-professional-development-cpd/continuing-professional-development-guidelines/

For CNHC CPD requirements please refer to www.cnhc.org.uk/index.cfm?page_id=29.

h) Cooperation and respect

You should at all times conduct yourself in an honourable and courteous manner in relation to other practitioners. Any comments you make about a fellow practitioner or other healthcare professional must be honest, accurate and sustainable. The terms 'practitioner' and 'healthcare professional' includes those people who are either nutritional therapists or those practising in other fields of alternative, complementary or orthodox medicine such as dieticians, GPs, specialists, consultants etc.
If you believe a colleague's conduct, health or professional performance poses either a risk to a client's wellbeing or is liable to bring BANT into disrepute then you are advised to use the BANT Complaints Procedure via the PPC.

The PPC follows a formal Complaints Procedure and Disciplinary Procedures –

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www.bant.org.uk/members-area/professional-practice/complaints-and-disciplinary-procedure/

You should not communicate any critical views of another practitioner's competence or behaviour to any third party or to the public. Such behaviour may be regarded as slanderous and may undermine public confidence in the profession. Such criticisms will be regarded as unprofessional. In the event that you become the focus of such views, you should act with discretion and express no opinion. This also applies when a client may come to you after having seen another NT practitioner.

It is unethical for you directly to encourage clients of other practitioners to transfer to your own practice. Where a client is referred to you by another practitioner to cover for holidays, illness or for any other reason, then you should respect those circumstances and not actively take advantage by encouraging those clients to continue with you.

The decision as to whether or not the client returns to the original practitioner must rest solely with the client, and any attempt made to persuade them to remain with, or return to you, is considered unethical and is regarded as soliciting.

i) Referral to other practitioners

You may wish to refer a client to another NT in cases of holidays, moving out of the area, closing down the practice, retiring or illness.

You must ensure that where a client consultation is delegated (whether you are present at or absent from the practice) it is delegated to a qualified practitioner who is a BANT member and who adheres to the requirements of the CNHC Code of Conduct, Performance and Ethics, as well as the information within the BANT Professional Practice Handbook.

You must be sure that the BANT practitioner has the knowledge, skills and experience to consult with the client safely and effectively and within their scope of practice.

If another BANT practitioner refers a client to you for any reason such as holidays, illness, maternity leave etc., with the intention that the client will return to the referring BANT practitioner you should inform the original BANT practitioner of all the advice given or recommendation made during their absence.

See client records in Section 2.5 b for more detailed information and advice.

j) Registered Medical Practitioners

During any consultation, a client with potential undiagnosed health problems should be recommended to seek medical advice, if this has not already been done, to ensure no underlying pathology has been overlooked.

If the client does not wish to consult a medical practitioner, this information must be recorded in the clinical notes.
You must not countermand instructions or prescriptions for medication given by a registered medical practitioner.

As a BANT practitioner, you should strive for a good relationship and full co-operation with medical and other recognised healthcare professions. Clients must not be led to believe that Nutritional Therapy replaces medical care.
www.bant.org.uk/members-area/professional-practice/guidelines-and-tools/red-flag-reminder/

k) Maintain a non-discriminatory stance at all times

You must avoid any unfair prejudice on your part. You must not allow your views on a client's lifestyle, age, gender, sexuality, religion, race, culture or social economic status to affect an appropriate assessment or care.

It is discriminatory to refuse to provide a service on a discriminated ground. The laws concerning anti-discriminatory practices include those relating to age, disability, political beliefs, race and ethnicity, religion, sex and sexuality.

l) Establish and maintain clear sexual boundaries with your clients and their carers

Personal relationships of a romantic or sexual nature with a client are unethical and treated as serious professional misconduct.

We recommend that you acquaint yourself with the Council for Healthcare Regulation in Excellence (CHRE) document on 'Clear sexual boundaries between healthcare professions and patients' obtainable from the following link:
www.unison.org.uk/healthcare/pages_view.asp?did=6439

m) Justify any refusal to continue to support a client

Although you are free to decide which individuals you accept as clients, you must be able to justify any decision to refuse to continue their nutritional therapy. Justification for this may be acceptable if:

- A client is aggressive or violent
- The client is putting you or your practice staff at risk
- The client is acting against your clinical advice
- The client's case exceeds your capacity and confidence
- The client has an ulterior motive for seeing you

2.4 Confidentiality and Consent

a) General guidelines

You (and any staff that you might employ) have an implicit duty to keep all information including names, attendances, records and views formed about clients entirely confidential. Clients have the right to expect you to observe confidentiality at all times; with certain exceptions (see Exceptions to confidentiality Section 2.4 b). This duty survives the death of any client.

No disclosure may be made to any third party, including any member of the client's own family, without the client's written consent unless such information is required by due process of law; whether that is by statutory instrument, or by order of any court of competent jurisdiction.

You must ensure that the confidential information for which you are responsible is at all times secure against loss, theft, fire and improper disclosure. Therefore any records that you keep must be properly secured to a level that any breach of confidentiality is extremely unlikely. Similarly electronic/computer storage should be password protected. This includes data on smartphones.

You may release confidential information regarding a client, to a person appointed by that client, with your client's explicit written permission to do so.

Provided that you do not otherwise breach the CNHC Code of Conduct, Performance and Ethics, you may refer to the details of any client's health status and the advice you gave, providing that the data is made fully anonymous, and without 'clues' as to the client's possible identity; e.g. in a teaching situation or a written article.

No third party including assistants or family member may be present during the course of the consultation without the client's consent and this must be noted in the client's file.

b) Exceptions to confidentiality

You may only disclose confidential information about your client without their consent if you are compelled to do so by order of a court of law, or other legal authority, or if to do so would be in the public interest. The latter may be necessary when it is deemed that your duty to society overrides your duty to your client. This situation may arise when a client puts themselves, or others, at serious risk, for example, through possible infection, violence, suicide or serious criminal act.

You may at times, and in the interests of your client's health, need to share confidential information with the client's medical advisor, legal guardian or close relative. In exceptional circumstances you may do so without consent, for example if the client is incapable of giving

consent or unreasonably refuses to do so or if it is undesirable on medical or other grounds to seek consent. In all circumstances where there is any doubt in your mind you must seek advice from BANT PPC (bantpractice@bant.org.uk).

A court of law may order you to disclose information without the consent of the client. If this happens you should only release the specific information you are ordered to release. You may wish to take legal advice in these circumstances before releasing information or documents.

You may need to allow an inspector of taxes to see your practice financial records. To protect your clients' confidentiality, financial affairs should be kept separate from your clinical notes.

c) Client consent

Ability to give consent is based on a person's capacity to understand, not their age. If someone is suffering from a mental incapacity, they (even if an adult) may not be capable of giving consent. This is set out in Section One of the Mental Capacity Act 2005.

The Adults with Incapacity (Scotland) Act 2000 provides ways to help safeguard the welfare of people aged 16 and over, who lack the capacity to take some or all decisions themselves because of a mental disorder or inability to communicate. Services in Northern Ireland are set out in the Comprehensive Legal Framework for Mental Health and Learning Disability - August 2007
(Easy Read Summary www.dhsspsni.gov.uk/legal-issues-easy-read-summary.pdf)

When working with clients in care homes you must obtain permission from the parent or next of kin responsible for your client's overall health issues. This person must be present in any consultations undertaken. You should also obtain permission from this person for the Careworker to be present at the consultation and for you to liaise directly with the Careworker if necessary.

d) Student observations

You may receive requests from nutritional therapy or medical students asking to observe your consultations. This is to be encouraged and is a CPD activity that you can record on your CPD log. However, you must ensure that such requests are from genuine students studying at an approved institution www.bant.org.uk/nutritional-therapy-careers/training-in-nutritional-therapy/ by confirming with their course leader or tutor.

When students arrive, you are encouraged to ask them to sign a confidentiality form for the protection of your clients. You must also request permission from each client for the attendance of the student in the consultation.

2.5 Commercial Issues

a) Data Protection

Data Protection is a legal issue.

It is important that all members acquaint themselves with the **Data Protection Act 1998**, which sets out the requirements for handling personal data and sensitive personal data. Personal data include data that identify living individuals. Sensitive personal data are information about racial or ethnic origin, political opinions, religious beliefs or other beliefs of a similar nature, membership of a trade union, physical or mental health or condition, sexual life and the commission, or alleged commission, of any offence and any related proceedings.

The Data Protection Act applies to all forms of media including papers and images. It applies to confidential client information but is far wider in its scope. It covers the holding, obtaining, recording, using and disclosure of information. Under the Act, everyone that processes personal information must notify the Information Commission's Office (ICO) at www.ico.gov.uk in order to register and pay the annual fee.

It is also recommended to read the BANT document which outlines the importance of Data Protection and offers some tips on how to protect the personal data concerning clients held by BANT practitioners.
www.bant.org.uk/members-area/professional-practice/guidelines-and-tools/data-protection/

b) Client records

Please note that you may be required to submit your notes to BANT PPC where a complaint has been raised against you.

i. You must keep legible, accurate, easily understandable and dated case notes. These notes should always be made in indelible ink and record, as a minimum:

- your client's personal details, i.e. name and address and dates of attendance
- all problems and symptoms reported by your client;
- relevant medical and family history;
- your clinical findings;
- the details and date of any advice, dietary plan, supplement recommendations or other advice given;
- advice given to the client regarding the issues or potential risks associated with any advice given;
- records of consent and/or consent forms;
- any functional testing you provided or arranged and their results;

- any communication with, about or from your client;
- copies of any correspondence, report, test results concerning your client;
- outcome of any recommendations that were given and any adverse reactions;
- where consultation took place and how e.g. clinic, home , face to face, telephone/skype;
- a summary of any text conversation;
- when a third party is present at a consultation e.g. member of client's family or student/observer;
- detailed notes of any telephone conversations along with dates and a summary of advice given;
- computer records – files should include emails copies, between client and the NT and any protocol /supplement programme that has been;
- signed copy of any Terms of engagement (ToE)

ii. You must give clients access to their personal health records, if they request them, in line with legislation.

c) Ownership and storage of records

In any situation where a BANT practitioner is self-employed, that BANT practitioner owns the client records. Where you, as a BANT practitioner are employed by an organisation or person, the records belong to the employer, but you have the responsibility to ensure that all the records are stored correctly.

You must keep client records safely and in a good condition for eight years from the date of the client's last visit to you or, if the client is a child, until his or her 25th birthday or 26th birthday if the client was 17 at the conclusion of the nutritional therapy.

Eight years is in line with the requirement that covers general NHS hospital records and other forms of health records. The purpose of this requirement is to ensure that the client has access to his or her recent health records and to provide protection for you in the event of a claim being made against you.

You must arrange for your client's records to be stored safely when you close down your practice or in the event of your death.

Transfer of Case Notes

In the event you wish to retire or sell or pass on your business or client base or individual clients, you will need to obtain your client's written consent to pass on any personal records

to a third party. We recommend that the original BANT practitioner continues to hold the original documents as detailed above and copies of the documents are passed to the new BANT practitioner.

See section 2.10 Discontinuing Clinical Practice.

d) Professional indemnity insurance

You must have full professional indemnity insurance as required by CNHC and BANT.

You are personally liable to your clients for any breach of duty or harm to them. You must ensure that you, and any staff you employ or who work on your premises, are adequately insured against professional negligence or any other claim brought by a member of the public. This insurance must cover all therapies you practise. You are also advised to have insurance covering the legal costs of defending any action against you.

Under the **Occupier's Liability Act (1957),** you are legally required to ensure you are adequately insured against accidents occurring on any premises that you own and use for your practice. If you practise at someone else's premises you are advised to check that those premises are insured against Occupier's Liability.

You must inform your insurance company of any changes in your circumstances that may affect your policy. You must ensure that your insurance has enough "run off" to protect you when you are closing your practise.

BANT does not administer insurance cover for its members but our members get preferential rates from the providers listed on the BANT website. Members receive renewal notices direct from their insurance provider.
If you choose not to take insurance with a BANT recommended insurer (www.bant.org.uk/nutritional-therapy-careers/join-bant/professional-indemnity-insurance/), you must declare on joining BANT and at each subsequent renewal, that you have appropriate insurance. **If this insurance lapses, your BANT membership will then become invalidated.**

If you intend to work outside of the United Kingdom, or wish to provide advice to any client who is not based in the United Kingdom, please ensure that you contact your individual insurer to establish the territorial limits of your professional indemnity cover before carrying out any work.

See also section 2.6 Health & Safety section regarding types of insurance.

e) Business name and partnerships

In all cases where a trading name is used other than that of the legal owner(s) (whether a company or an individual or a group of individuals) the member must abide by the provisions of the Business Names Act 1985. Details of these provisions can be obtained from the local trading standards office or www.tradingstandards.gov.uk.

Changes in partnership should be noted as soon as they occur. Where a limited company, or limited liability partnership, is formed, it must comply with the provisions of the current Companies and other Acts.

f) Sale and recommendation of products and services

As a member of BANT, your main income as a Nutritional Therapist should derive from consultative, advisory, educational and promotional aspects of nutritional therapy. You may also supply supplements you recommend to your client as an integral part of a consultation. In addition, you may also act as a supplier of laboratory tests, or any other products, related to nutritional therapy.

You may choose to benefit from trade discounts and commission payments when offered by the supplier on products purchased by you for such use. You may also choose whether such payments, in whole or in part, are retained in your nutritional therapy business, or passed onto the client. However, to protect both you and the client, both parties must be in a formal client relationship and implementing the prescribed nutrition programme, timings, review meetings and record taking as arranged initially between the parties.

If you recommend products or services to clients, you must, at the time of recommendation, declare any financial benefit you may receive for this. In addition you must only recommend products or services that will, in your professional judgement, be most appropriate for your client.

You should at all times put the client's health and specific individuality first and only recommend supplementation if it may benefit the client and not for your own financial gain. What is important is that the 'incentive' does not sway your judgement and professional recommendation to your client.

Under the BANT logo, you may not recruit or induce members of the public to sell nutritional supplements, upon which you will earn commission, to a third party.

It is important for members selling supplements to be aware of the following:

- the European regulations and ASA advertising guidelines with regard to supplements. See section on Legislation –

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www.cap.org.uk/Advertising-Codes/Non-broadcast-HTML/Section-15-Food,-food-supplements-and-associated-health-or-nutritional-claims.aspx

- the relevant regulations for the country if you are working outside the UK

- supplements should actually only be recommended as part of a full nutritional therapy consultation; so if you are selling to members of the public without a consultation, these should not be practitioner supplements but general supplements suitable for use by members of the public.

- you should make it clear that the supplements you sell have been checked for safety and quality and the brands stocked adhere to the stands set out by the EU vitamins directive.

- supplements being sold need to be within the normal scope of NT practice refer to links https://tools.skillsforhealth.org.uk/competence/show?code=CNH8 and https://tools.skillsforhealth.org.uk/competence/show?code=CNH9

- if you are selling supplements on a website, they should be sold from a clearly distinct area of the website (or ideally, a separate website) from your nutritional therapy pages, and not from pages showing the BANT logo.

- you should also make sure you have prominent disclaimer warning that supplements should be taken under the guidance of a doctor or nutritional therapist, that taking different supplements together could result in too-high doses of common ingredients, and that anyone taking prescription medication should inform their GP before taking supplements of any kind.

It is illegal to prescribe or administer hormones (to include sex, adrenal, pituitary, thyroid) that are licensable medicinal products unless you are medically qualified. It is acceptable to test for hormonal status and then advise clients to consult a medical practitioner with your recommendations.

Selling food products or own label products

If you choose to sell homemade products to paying clients then there are Food Safety aspects that you will need to adhere to i.e. the products would need adequate preservation, with appropriate storage recommendations, and an indication of a 'best before' if quality related, or 'use by' if safety related.

All food(s) produced for public consumption has to be properly labelled and safe for consumption. The premises where the products are being made have to be licensed by the local authority. They will provide you with more detailed information and how you can comply with regulations.

It is also advisable to familiarise yourself with the Consumer Protection Act 1987. You can purchase a fact sheet on the Guide to the Consumer Protection Act from www.scavenger.net/consumer-protection-act-1987.

The factsheet explains what the Consumer Protection Act 1987 covers, who it applies to and what obligations the legislation places on businesses. It also provides hints and tips and sources of further information.

When considering own-labelling of food products you must comply with all the relevant legislation, which includes such issues as packaging, permitted additives, labelling, weights and measures. This is a complex area and you are advised to seek expert advice. The Food Standards Agency website provides details of the relevant legislation - see www.food.gov.uk/enforcement.

g) Disclosure

You should declare to your client any financial or other benefit you receive for introducing him or her to other professionals or to any commercial organisations.

You must disclose whether you are a shareholder, director, owner, employee in, or consultant to, or have any other similar interest in, companies or associations that supply products and services.

Disclosure can be verbal or in writing.

h) DBS Checks (formerly known as CRB Checks)

The Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) have merged into the Disclosure and Barring Service (DBS) - CRB checks are now called DBS checks.

www.gov.uk/disclosure-barring-service-check/overview
For guidance when working with schools, there will be clear policies and it may be helpful to contact your local education authority for local information.

i) Other Modalities

You must make a clear distinction between any different modalities you may practise, so that your client knows what to expect and is absolutely clear about the approach(es) you are using, not just in client consultations, but in all your publicity materials and website.

In practice this means that if you wish to use any modalities other than nutritional therapy with your clients, you must:

- explain fully any other modality you wish to offer to the client so that they understand what is involved and how the approach might help them, and can make an informed choice about any other modality that is offered that is not nutritional therapy.
- use separate Terms of Engagement for each modality that you practise.
- ask the client to sign a separate Terms of Engagement document for each modality that you use with them that is not nutritional therapy.

The role of a BANT nutritional therapist does not include the practice of other non-nutritional modalities. When a BANT nutritional therapist also practises another modality, it must be made clear that this falls outside the scope of BANT and the BANT logo may not be used on any promotional material/website for these modalities.

2.6 Health and Safety

You must comply with Health and Safety and Fire legislation in your work environment. It is recommended that all NTs are familiar with the **Health and Safety at Work Act 1974** (www.hse.gov.uk/legislation/hswa.htm). This is the primary piece of legislation covering occupational health and safety in the UK.

a) First Aid

Members are not legally required to undertake first aid training. It is however recommended that Practising Members attend a one-day 'First Aid in the Workplace' course and be able to apply its recommendations as and when required, as stated under the Health and Safety Executive Approved Code of Practice L74 1997.

Nutritional Therapy practitioners are required to complete an annual Practice Self Audit tool which contains health and safety points relating to your practice and is available to download from the members section of the BANT website – www.bant.org.uk/members-area/professional-practice/guidelines-and-tools/first-aid/

It is further recommended that knowledge be updated at least every 3 years.

b) Insurance

You should ensure that you have the correct insurance in place that covers you working from home or in clinic.

Public liability – covers you if a client is injured on your premises or if their personal property is damaged in anyway.

Employer's liability – this will only be relevant if you have people working for you e.g. should a member of staff have an accident on the premises and then attempts to prove that the accident came about as a result of your negligence.

Product liability – this is important if you are planning to use or sell products as part of your business.

In addition to the above, each BANT practitioner must be aware of and comply with the relevant by-laws of the local authority. Furthermore, your local authority may require you to obtain a licence to practice, and it is your responsibility to investigate if this is the case where you practise.

c) Lone working

Many BANT practitioners work alone from their homes. We recommend that you familiarise yourself with the BANT guidelines on lone working. These are intended to highlight areas that may require attention and to raise awareness of the possible risks whether working from home or in a clinic.

www.bant.org.uk/members-area/professional-practice/guidelines-and-tools/guidelines-for-lone-working/

d) The home as business premises

Where you run a practice from home, you should ensure that you are entitled to do so under the lease agreement or other title deeds. You should also comply with any relevant business and insurance requirements.

You must ensure that your home is properly suitable for a professional consultation.

e) Risk from you

You should ensure that your own physical and mental health does not put any client at risk.

f) Self Audit

As a BANT practitioner it is prudent for you to conduct an audit of your practice at least once a year in order to review your practice and to familiarise yourself with the process of self-audit. This audit tool can be used regardless of whether you practise from home, rent premises or are employed. It is based on the requirements for the training of Nutritional Therapists as set out in the NOS https://tools.skillsforhealth.org.uk/competence/show?code=CNH8,

https://tools.skillsforhealth.org.uk/competence/show?code=CNH9 and NTC Core Curriculum www.nutritionaltherapycouncil.org.uk/trainers-1_17_3240151082.pdf

2.7 Legislation

a) Legislation relating to advertising and diseases

It is illegal for you to prescribe a cancer remedy, or to advise such, or to make any claim to ‘treat’ cancer.

It is an offence to advertise any therapy, procedure or product to treat the following diseases: Bright's disease; glaucoma; cataract; locomotor ataxia; diabetes; paralysis; epilepsy or fits; tuberculosis; hepatitis; motor neurone disease.

The law states that whilst there is no prohibition on advising clients suffering from any disease, in each case the offence is in advertising ’treatment’.
As a BANT Nutritional Therapist you are not allowed to diagnose medical conditions - this is the sole domain of registered healthcare professionals. Naturally, we will come across symptom clusters that suggest certain conditions may be present. However, when this is the case, it is imperative that you refer such clients to their GP for a formal diagnosis.
As a BANT practitioner, you should strive for a good relationship and full co-operation with medical and other recognised healthcare professions. Clients must not be led to believe that Nutritional Therapy replaces medical care.
www.bant.org.uk/members-area/professional-practice/guidelines-and-tools/red-flag-reminder/

BANT does not permit any advertising that makes any form of curative or unattainable claims, as this may lead to legal claims of misrepresentation being brought against you.

For example, the statement that 'Vitamin B3 can lower cholesterol levels' is an unacceptable claim when advertising the sale of nutritional supplements.

Members should familiarise themselves with the requirements of the Food Standards Agency (www.food.gov.uk) and the BANT briefing note on the EU health claims regulation April 2008 – www.bant.org.uk/http://bantuat.scottparker.co.uk/centre-of-excellence/submissions-and-responses/

2.8 Advertising

a) General Guidelines

The interests of the clients must remain paramount at all times in matters concerning advertising.

Although advertising of a solely commercial nature is not encouraged, BANT does recognise the need for some form of publicity to promote the profession of Nutritional Therapy, otherwise it may be difficult for members to access clients.

You may gain such access through:

- Referrals
- Public lectures
- Written article
- Personal media appearances
- Internet
- Social media
- Leaflets

All advertising carried out by you, or by someone on your behalf must follow the law and guidance issued by the Advertising Standards Authority (ASA).

The ASA is the UK's independent regulator for advertising across all media and it applies/regulates all Advertising Codes written by the Committees of Advertising Practice (CAP). Further information about the ASA can be found via this link: www.asa.org.uk/About-ASA.aspx

It is the ASA's remit to ensure that all marketing is: Legal, decent, honest and truthful.

To find out which commercial communications the ASA monitors please refer to the BANT PR Toolkit – www.bant.org.uk/centre-of-excellence/knowledge-sharing/resources/toolkits/

If you practise in a residential or multi-disciplinary clinic or are considering so doing, you must ensure that your part in any publicity or advertising is in keeping with the CNHC Code of Conduct, Performance & Ethics and the BANT Professional Practice Handbook.

You are responsible for ensuring that your advertisements appear in locations that are appropriate to professional practice, for example libraries, dental practices, GP surgeries etc.

You may advertise in bona fide directories issued or registers (printed or online), for example, by newspapers, commercial enterprises, libraries and health associations, even if payment is required. You should ensure that you do not discourage these directories from inviting other members of BANT, or other healing professions, from also appearing.

Direct advertising through unsolicited canvassing, door-to-door visits, leaflet drops, telephone or personal visits including emails is not allowed.

We would like to re-iterate that it is your responsibility to ensure that your publicity materials comply.

Essential Practice Information

You may distribute essential practice information such as name, qualifications, addresses, telephone numbers, hours of business and 'creche' availability, as well as information about nutritional therapy, to medical practitioners, dispensing chemists, libraries, information centres, Citizens' Advice Bureaux, health food stores, health clubs and leisure centres.

Where fees are quoted in an advertisement, there should be clarity on what they include.

You must meet the requirements of the local planning authority when using a practice name plate.

Advertising Support and the CNHC

You also need to be aware that the CNHC has worked with the Committee of Advertising Practice (CAP) Copy Advice team and BANT to produce the wording to describe Nutritional Therapy.

The purpose of this is to offer you wording that you can use to describe your practice in a way that will reduce, to a very great extent, the risk of a successful complaint to the ASA.

The CNHC will keep registered practitioners updated about any amendments to the wording which will result from any future ASA adjudications. The CNHC has also produced Advertising Guidance in consultation with CAP and this can be downloaded from the CNHC website under 'Publication/Guidance Sheets' - www.cnhc.org.uk/index.cfm?page_id=87.

b) Literature

You may circulate literature intended to educate and inform the public about the work of a nutritional therapist and the scope of your services. Such literature must be presented in a strictly professional style and format.

You may also make relevant literature available to members of the public if an interest is shown. For example, leaflets may be left in a practice reception area with permission, or posted at the request of an individual, or made available on request at conferences, seminars and other similar events.

You may publish books, pamphlets and articles of an informative nature about nutrition and other relevant subjects. Such publications must however be of scientific or educational value and should avoid matters that might be construed solely as personal advertising.

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If there is any doubt about the suitability of any publication, directory or any proposed wording, you should consult the BANT Communications Team communications@bant.org.uk.

c) Media Publicity

You must ensure that participation in any form of publicity, be it in the press, on television or radio, or in public meetings or similar, is educational in content and cannot be construed as advertising.

You must also be aware that when asked for comment by a newspaper (especially a national newspaper) or an edited television or radio programme, you may have little or no control over the final published or broadcast format, and you may need to seek expert advice first (BANT Communications Team communications@bant.org.uk) to avoid unintended outcomes.

You must also ensure that your own publicity does not in any way damage your public image, the profession or the interests of BANT and the CNHC.

2.9 Disciplinary and complaints procedures

a) Investigation by BANT

Complaints are to be sent directly to the Professional Practice Committee (PPC).

www.bant.org.uk/members-area/professional-practice/complaints-and-disciplinary-procedure/

BANT practitioners should inform BANT whenever they are subject to a complaint or an investigation regarding their nutritional practice, and also when subject to legal or police action.

If a BANT practitioner requires advice on a professional or ethical matter he or she should consult the PPC.

In cases of allegations against a BANT practitioner, where BANT is satisfied that the allegations are unjustified, BANT will offer all necessary moral and professional support to the BANT practitioner in any legal proceedings.

Any BANT practitioner who breaches the provisions of the CNHC Code of Conduct, Performance and Ethics and the information set out in the BANT Professional Practice Handbook, shall be liable to BANT’s Disciplinary Procedures, including warnings and/or membership to be rescinded.

www.bant.org.uk/members-area/professional-practice/complaints-and-disciplinary-procedure/

b) Investigation by other professional bodies

If you are subject to any investigation or adverse decision by another professional body, whether in healthcare or otherwise, you must notify BANT PPC and give full details as soon as reasonably practical.

c) Criminal Offence

If you are convicted of a criminal offence or have accepted a police caution, then you must inform BANT and the CNHC and give full details within at least 28 days of the conviction. Each case will be considered individually and a decision made in the light of the circumstances of the case.
Your BANT membership and CNHC registration may be at risk if you are convicted of a criminal offence that involves, for example, one of the following types of behaviour:

- Violence
- Abuse
- Sexual misconduct
- Supplying drugs
- Drink-driving offences where someone was hurt or killed
- Serious offences involving dishonesty
- Any serious criminal offences for which you received a prison sentence

2.10 Discontinuing Clinical Practice

When you finally decide to stop practising to either retire or move on to other ventures there are considerations that need to be taken into account:

- If you intend to stop practising, you will at the very least need to let on-going clients know what is happening and when, preferably in writing, and give them advice on finding an alternative Nutritional Therapist.

- If you wish to pass your business on to a particular Nutritional Therapist, you must write to all your ‘active’ clients and seek their permission to pass their case notes and records on to the new therapist. To facilitate this you may find it useful to include a consent form that the client just has to sign and date, with a stamped, addressed envelope.

- You must keep your insurer informed of what you are intending to do and let them know when you stop practising.

- You will need to keep copies of all your case notes for eight years in case a retrospective complaint or action is taken against you.

- You will need to keep records of your accounts for a minimum of six years for HM Revenue and Customs.

- It is also advisable to arrange secure disposal of client files in the event of a death.

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Section 3 – Handbook Amendments

Appendix 1.

Section 1.4

1) To investigate complaints against a BANT member by another BANT member but only where the complaint relates to the member's professional practice in their work with clients or other activities associated with applied nutrition (e.g. teaching, supervision, writing etc).

CNH8 Provide Nutritional Therapy to clients

OVERVIEW

This standard is about providing Nutritional Therapy to clients. Nutritional Therapy Practitioners work in preventive medicine, the optimization of physical and mental health, and in the treatment of chronic diseases, often with complex multiple causes. Nutritional Therapy encompasses personalized dietary therapy and nutraceutical prescription, and life style advice within a functional medicine framework.

The scope of practice for Nutritional Therapy excludes artificial (parenteral/enteral) feeding and dietary management of acute life threatening states, e.g. intestinal or renal failure, and injury trauma.

Users of this standard will need to ensure that practice reflects up to date information and policies.

Version No 1

KNOWLEDGE AND UNDERSTANDING

You will need to know and understand:

1. the historical development of the therapy and the profession
2. the concepts underpinning functional systems biology/medicine, and patient centred approaches
3. the concept of Nutritional Therapy as a process driven modality
4. the concepts underpinning CAM, and integrative and orthodox medicine
5. roles that evidence-based and traditional research play in informing clinical decision-making
6. how to use questionnaires and diaries to optimise gathering of information
7. methods for obtaining and recording anthropometric measurements
8. methods for conducting and recording observations of health status
9. how to select, when appropriate, biochemical, nutritional and functional tests
10. how to use support materials, resources and information to increase compliance
11. how to communicate with other health professionals to provide a client-centred integrated approach

12. how to use the clients story as a key tool for integrating diagnosis, signs and symptoms, and evidence of clinical imbalances into a comprehensive approach to improve both the patients environmental inputs and physiological function
13. how to apply a functional systems biology/medicine, and patient centred approach
14. how to use prognosis to rationalize strategies for prioritisation, and timeline planning
15. how to identify situations in which it may be appropriate to delay implementing all or part of a treatment plan
16. ways in which individual safety may be compromised by inappropriate treatment and how to minimise such risks
17. how to interpret and evaluate data from observations and laboratory tests
18. how to use diverse sources of information to provide a personalised plan
19. how to synthesize new information and modify the treatment plan over successive consultations
20. issues in translating government guidelines, epidemiological, and other research findings to the construction of individualized interventions
21. models of reflection and how these are applied to practice
22. strategies for managing potential dissonance between expected and actual treatment outcomes for self and client
23. the relationship the client has with food, food groups and dietary models
24. how different cultures describe effects of food on health
25. how to conduct quantitative and qualitative analyses of food intake
26. how to balance quality, quantity, variety and therapeutic effect to achieve negotiated goals, redress deficiency, modulate/optimize functional status or for palliation
27. uses of transitional, alternative and functional foods, recipes and menu plans to increase compliance
28. how to a construct ethical and environmentally sensitive dietary advice
29. how to identify potential food drug and nutraceutical interactions
30. risks - benefits of foods or dietary models, historical and current, used to modulate antecedents, triggers and mediators
31. the approach of orthodox dietetics in prevention and treatment, including enteral and parenteral nutrition, to facilitate collaboration and identify professional boundaries
32. the nature and extent of changes to performance or symptoms expected
33. how to distinguish perceived negative effects that may be experienced by individuals from other causes of change
34. how changes are explained by nutritional therapy principles
35. how to enable individuals to recognise progress
36. the purpose of supporting the individual to consider the implications of any changes which are made to the treatment
37. the use of audit to monitor all aspects of a programme
38. the sources, classification, biochemical structures and related functions, interactions of and therapeutic considerations of macronutrients, micronutrients, secondary plant metabolites and other non-nutritive substances
39. factors affecting individuals requirements: bioavailability, absorption, transport, metabolism and excretion, endogenous and exogenous xenobiotics, impact of genetics and disease
40. the integration, coordination, and regulation of metabolic pathways by hormones and bio-molecules, nutrients and nutraceuticals
41. interaction of nutrients, non-nutritive substances and nutraceuticals with the

human genome including epigenetic effects

42. traditional and novel uses of nutrients and non-nutritive substances
43. how requirements and reference intakes through the life stages are determined
44. the chemical composition of food and its effects on health and disease
45. use of food composition tables and nutritional databases
46. effects of food adulterants and contaminants on health
47. effects of production, processing and preparation on food quality, health and the environment
48. nutrient, phytonutrient content of foods and their effects on bioavailability
49. the diversity of adverse reactions to foods and functional foods
50. how regulations relating to labelling and health claims impact on practice
51. the functioning and web-like interaction between tissues and organs at the, cellular and systemic levels
52. the core clinical imbalances that underlie various disease conditions
53. the clinical signs and symptoms generated by the bodys response to stress, poor nutrition, insult or injury through exposure to endogenous and exogenous toxins, allergens, infectious agents, parasites, other environmental factors, genetic predisposition, emotional and psychosocial factors
54. common biomedical terminology used in pathology
55. the aetiology and pathology of common diseases and their clinical features
56. the impact of microbiota on health
57. how to ascertain the sensitivity, specificity and validity of diagnostic tests
58. selection, use and evaluation of tests of biochemistry, pathology, microbiology genetic information, and functionality in diagnosis and monitoring
59. differential diagnoses of common conditions and diseases
60. boundaries to practice including:
    1. which conditions should be referred (the red flag list)
    2. which signs and symptoms, and test results warrant further investigation
    3. high-penetrance single-gene disorders

PERFORMANCE CRITERIA

You must be able to do the following:

1. conduct a nutritional and overall health assessment, and plan the therapy
2. ensure that the environment meets the clients needs
3. ensure that any equipment and materials are ready for use
4. provide clear and accurate advice to the client in relation to nutritional therapy
5. select, implement and interpret appropriate assessments and tests for the client and to inform decision-making
6. ensure that when referring to or collaborating with other healthcare providers communication is accurate and supports the needs of the client
7. implement nutritional therapy safely and in accordance with professional codes of practice, legal and organisational requirements
8. make appropriate adjustments to the nutritional therapy to meet any changing needs

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9. check the clients well-being throughout and give reassurance where needed
10. educate the client to implement nutritional therapy, and any relevant aftercare and self-care
11. critically evaluate the outcomes of the nutritional therapy programme to inform future plans and actions
12. critically appraise areas for self-development within the context of continuing professional development planning

ADDITIONAL INFORMATION

This National Occupational Standard was developed by Skills for Health.

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: HWB7 Interventions and treatments

This standard has replaced CH NT1 and CH NT2.

Related Functions

Principles of Good Practice

CNH1 Explore and establish the client's needs for complementary and natural healthcare

CNH2 Develop and agree plans for complementary and natural healthcare with clients

B

Skills for Health

CNH9 Prescribe nutraceuticals to clients

OVERVIEW

This standard is about the ethical prescribing of nutraceuticals to clients. The Nutritional Therapy Practitioner links theory to practice through the critical appraisal of a diversity of information sources.

Users of this standard will need to ensure that practice reflects up to date information and policies.

Version No 1

KNOWLEDGE AND UNDERSTANDING

You will need to know and understand:

1. principles of pharmacokinetics, pharmacodynamics and hormesis
2. general mechanisms of action, possible side effects including induced nutrient deficiencies, and contra-indications of commonly used drugs
3. factors affecting variability of responses to drugs and nutraceuticals including genetic influence, age, gender, health status, diet and lifestyle
4. possible consequences of drug/food/nutraceutical/phytonutrient/herbal medicine/xenobiotic interactions
5. how effects and side effects of drugs may affect diagnosis and prognosis
6. how to use standard reference sources for information about named drugs
7. how to appraise models of research and research findings used to trial drugs and drugs with diet and or nutraceuticals and translate to practice
8. models of prescribing and how to apply in practice
9. how form, formulation, and standardization affect bioavailability, synergy and antagonism, pharmacokinetics and pharmacodynamics, toxicity and safety
10. how to determine dosage and timing of intake to rectify clinical or subclinical deficiency, and modulate antecedents, triggers and mediators of systems dysfunction
11. prophylactic and palliative uses of nutraceuticals
12. factors to consider when selecting nutraceuticals and how these may affect individuals' response to such nutraceuticals including disability, religion, moral

stance, socioeconomics, lifestyle, motivation and potential compliance

13. risk-benefit factors to consider when deciding on nutraceuticals, and how these various factors may affect individuals' reactions to such nutraceuticals
14. how to adjust a prescription in relation to dietary and lifestyle modification, test results, past, current and future medication, and other interventions and treatments
15. appropriate use of terminology and abbreviations when recording findings and communicating with other health professionals
16. issues in translating government guidelines, research findings, traditional texts and promotional materials to the construction of individualized prescriptions
17. how to prescribe ethically, cost effectively and with regard to the environment
18. relevant governmental and professional regulations
19. how timing of intake, storage and handling may affect the safety, integrity and effect of nutraceuticals
20. the nature and extent of changes to performance or symptoms expected
21. perceived negative effects that may be experienced by individuals and how to distinguish these from other causes of change and advise on appropriate action
22. how to report adverse events
23. how changes are explained by nutritional therapy principles and philosophy

PERFORMANCE CRITERIA

You must be able to do the following:

1. select a prescribing methodology which is appropriate for the client based on the assessment
2. identify nutraceuticals in accordance with the assessment and prescribing methodology select the nutraceuticals appropriate for the client and the stage of their treatment
3. prescribe nutraceuticals that are most likely to give optimum benefit to the client
4. dispense nutraceuticals to the client safely, or arrange for safe dispensing to take place
5. explain the nutraceuticals and possible responses to the client
6. encourage the client to monitor their condition and response to the nutraceuticals, and note any changes in their health and well-being
7. communicate with other health care professionals as is appropriate
8. evaluate compliance with and outcomes of the nutraceutical prescription in the context of dietary therapy and lifestyle advice to inform future plans and actions
9. complete and maintain records in accordance with professional and legal requirements

ADDITIONAL INFORMATION

This National Occupational Standard was developed by Skills for Health.

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: HWB7 Interventions and treatments

This standard has replaced CH NT1 and CH NT2.

Related Functions

Principles of Good Practice

CNH1 Explore and establish the client's needs for complementary and natural healthcare

CNH2 Develop and agree plans for complementary and natural healthcare with clients

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CORE CURRICULUM FOR NUTRITIONAL THERAPY

Interim Revision of Core Curriculum pending outcome into research on profession. Research to be carried out summer 2014.

Doc: NTEC/CC/14

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Section 1 Introduction

This document contains the Nutritional Therapy Education Commission (NTEC's) Core Curriculum (CC) for Nutritional Therapy (NT) and is applicable to all education providers training Nutritional Therapists.

This CC forms the skeleton around which the delivery of a course or programme leading to the practice of NT should take place. As such, it sets out the minimum standard required for independent, safe and effective practice and covers everything within the following standards:

Standards

1.2.1 Skills for Health National Occupational Standards (NOS) CHN1, CNH2, CNH8 and CNH9, subject to the Committee of Advertising Practice (CAP) guidance on Health Therapies and Evidence

1.2.2 SEEC Descriptors:

I. Development of Knowledge and Understanding
II. Cognitive/Intellectual skills
III. Key/transferable skills
IV. Practical skills

1.2.3 Framework for Higher Education in England, Wales and Northern Ireland (FHEQ) levels 4 Certificate of Higher Education and Level 5 Higher National Diplomas

The SEEC Descriptors, FHEQ and the NOS should be read in conjunction with the CC.

These standards set out the knowledge, understanding and skills which support the achievement of the NOS, demonstrating and facilitating a direct and clear relationship between knowledge and action.

The NOS does contain the words ‘treatment’ and ‘treat’. Should a training provider use these words within any part of a course, there must be evidence to support the use in a scientifically evidenced manner as set out in clause 4 and 5 of the CAP guidance on Health Therapies and Evidence.

Section 2 Competencies

2.1 Action required of Nutritional Therapist to meet NOS

Education should encourage the development of a Nutritional Therapist to be reflective, evidence based and research-minded. The education should encourage the adherence to all current relevant legislation including codes of practice of CHNC the voluntary regulator for Nutritional Therapists and BANT the professional body for Nutritional Therapists CHNC 2014, BANT 2014). Such training should include a range of transferable skills as outlined in appendix 1 (QAA 2014).

2.2 Definition of Nutritional Therapy

Nutritional Therapy is the application of nutrition science in the promotion of health, peak performance and individual care. Nutritional Therapy practitioners use a wide range of tools to assess and identify potential nutritional imbalances and analyse how these may contribute to an individual's symptoms and health concerns.

This approach allows Nutritional Therapists to work with individuals to address nutritional balance and help support the body towards maintaining health. Nutritional therapy is recognised as a complementary medicine and is relevant for individuals with chronic conditions, as well as those looking for support to enhance their health and wellbeing.

Practitioners consider each individual to be unique and recommend personalised nutrition and lifestyle programmes rather than a 'one size fits all' approach. Practitioners never recommend nutritional therapy as a replacement for medical advice and always refer any client with 'red flag' signs or symptoms to their medical professional (see appendix I). They will also frequently work alongside a medical professional and will communicate with other healthcare professionals involved in the client's care to explain any nutritional therapy programme that has been provided. (BANT 2014).

2.3 Clinical Practice

The overall aim of clinical practice must be to prepare a lawful, safe and effective Nutritional Therapy practitioner who is able to practice with autonomy. Clinical practice assessment must be conducted in a realistic working environment (situational assessment) and be fully supervised (observed). This will require a significant amount of commitment on behalf of both the HE provider (TP) and the student.

TP's will need to demonstrate that their graduates are competent to practice safely to comply with CHN1 and CNH8 The Accreditation Committee, as part of the accreditation process will require that Training Providers demonstrate that they meet the requirements in section 1: 1.2.1,1.2.2 and 1.2.3.

2.4 Transferable skill

In line with QAA guidance…transferable skills should also be embedded in programmes (see appendix II)

2.5 Assessment

Assessment methods must demonstrate an evolving process of complexity and preparation to practice in a professional capacity and assessment methods must relate to the Learning Outcomes. These must be based on the SEEC and CHN1, CNH2, CNH8 and CNH9.

Professional competence to practice as a Nutritional Therapist requires an effective synthesis of a wide range of knowledge and skills and students must demonstrate intellectual flexibility within a realistic clinical practice on completion. This must be based on FHEQ level 5 as a minimum standard and training may exceed this level. Full details of the framework can be accessed via the QAA website www.qaa.ac.uk.

The method of assessment to be decided by the training providers and should support the development of practice.

2.6 Academic Assessment Method

There should be both formative and summative assignments, with the formative assessment information as the basis of the summative function. The assessments should form a variety of essays, various tests including multiple choice and examinations, some of which may be conducted as open book. There should be a wide variety of other assessment methods; these could include oral presentations and discussions, poster presentations, and production of leaflets, information sheets, specific literature review, evaluation of a nutritional therapy approach for a named disease or perhaps evaluation of a scientific paper. All assessment methods should embed one or more of the Transferable Skills appendix II.

2.7 Clinical Assessment

Clinical practice assessment must be conducted in a realistic working environment and be supervised and observed. Students should conduct a series of nutritional therapy consultations. They should reflect upon their interaction with patients and their own development as a practitioner and record the diversity of evidence generated from these events in a portfolio. Assessments using a portfolio of tutor assessed competencies, feedback and action plans, clinical case evaluation report and reflective account develops the student's work- place skills, Transferable Skills and skills required for continuing professional development. This is the ideal method of collecting evidence of clinical assessment but is not compulsory.

2.8 Study time

The minimum length of study time has been determined by the NTEC as a total of 1500 study hours including appropriate clinical studies.

2.9 Treatment

The Committee of Advertising Practice (CAP) states, in clause 4 and 5 of the guidance on Health Therapies and Evidence, that the use of the word "treat" or "treatment" must be scientifically evidenced.

2.10 Competency, Knowledge and Understanding required of Nutritional Therapist

Throughout the document letters and numbers in parentheses follow the competency required to be met and these will relate to the following table and originate from the NOS. A more detailed list of the NOS can be found on the BANT and NTC website.

Section 2 Competency

NOS - See appendix 1 for full details

1. CNH1 Explore and establish the client's needs for complementary and natural healthcare

   Knowledge and Understanding (KU) 1-16 Performance Criteria (PC) 1-10

2. CNH2 Develop and agree plans for complementary and natural healthcare with clients

   Knowledge and Understanding (KU)1-11 Performance Criteria (PC) 1-6

3. CNH8 Provide Nutritional Therapy to clients Knowledge and Understanding (KU) 1-60

   Performance Criteria (PC)1-12

4. CNH9 Prescribe nutraceuticals to clients Knowledge and Understanding (KU)1-23 Performance Criteria (PC) 1-9

SEEC Descriptors across NOS 1-4

I. Development of knowledge and understanding

II. Cognitive/Intellectual skills

III. Key/transferable skills

IV. Practical skills

HE Level 4 (HEL4) across (NOS 1-4)

I. Knowledge of underlying concepts and principles and to evaluate and interpret these

II. Present, evaluate and interpret qualitative and quantitative data in accordance with basic theories and concepts.

HE Level 5 (HEL5) across NOS/CHNC 1-4

I. Knowledge and critical understanding of the well established principles of their area(s) of study, and of the way in which those principles have developed.

II. Ability to apply underlying concepts and principles outside the context in which they were first studied, including, where appropriate of the application of those principles in an employment context

III. Knowledge of the main methods of enquiry and the ability to evaluate critically the appropriateness of different approaches to solving problems

IV. An understanding of the limits of their knowledge, how this influences analyses and interpretations.

Section 3 Core Element

This section outlines the areas that a student to achieve to gain competency. It is split into two areas, Health Science and Clinic. These two areas have been divided for the purpose of clarity, incorporating the knowledge and understanding headings from the NOS CNH1,2,8 and 9.

The subject headings are not indicative of module titles nor structure. Institutions are encouraged to adopt an integrated approach to reflect the progress from health to disease and the possibility for intervention with nutritional therapy.

Aims are overall intentions on the part of the programme. Where more than one level is indicated this is intended to show progression of increased complexity of this subject during the course of study. Learning outcomes are reflective of the level of competence anticipated on completion of the subject and it is suggested that training providers revisit subject material at various stages throughout the course.

The importance of reflective practice should be acknowledged and incorporated throughout. Course design and the methods by which training providers wish to implement the aims and learning outcomes are the responsibility of the individual institution.

Accreditation procedures will ensure that all aims and learning outcomes are met. Accreditation documents will be available separately.

3a.1 Anatomy and Physiology

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To provide integrated knowledge of those aspects of anatomy and physiology which are essential for understanding health and the mechanisms and clinical features of disease	3a.1.1	Explain basic physical terms and anatomical directions related to the body, and land mark the organs, glands, major blood vessels and lymph glands. Describe functions of organelles including cell division and protein synthesis.	CNH1 KU15 CNH8 KU54			
To ensure an understanding of the web like interaction of physiological processes	3a.1.2	Describe the functioning of the major physiological systems** of the body and the integration within the body as a whole. ** skeletal, muscular, Nervous, sensory, endocrine, respiratory, digestive, urinary, reproductive, circulatory, integumentary, lymphatic & immune	CNH1 KU15			
To understand the effect of genetic factors on cell metabolism and function	3a.1.3	Explain the maintenance of homeostasis	CNH9 KU1			
	3a.1.4	Distinguish between the concepts of nutrigenomics and nutrigenetics. Explain how genetic changes including single nucleotide polymorphisms (SNPs) can affect gene function Discuss the concept of epigenetic regulation of gene expression”	CNH8 KU39,41 60.3	All	All	All

3a.2 Biochemistry / Macronutrients

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To understand the structure and function of water and the macronutrients:	3a.2.1	Explain the co-ordination and regulation of metabolic pathways by hormones and bio molecules, nutrients and nutraceuticals.	CNH8 KU38,40			
• proteins, • lipids, • carbohydrates	3a.2.2	Describe bonding and molecular interactions in biological compounds.	CNH8 KU38			
nucleotides and their anabolic and catabolic processes, including energy	3a.2.3	Explain properties of water and buffers in biological systems.	CNH8 KU38			
production within cells, and their control at molecular, cellular, tissue and whole body levels.	3a.2.4	Describe structural characteristics and functions of carbohydrates, lipids, proteins, enzymes, nucleic acids.	CNH8 KU38			
	3a.3.5	Explain the importance of enzyme co factors in major metabolic pathways.	CNH8 KU40			
	3a.3.6	Discuss the evidence for the effects of different dietary models on health risks	CNH8 KU30	All	All	All

3a.3 Micronutrients, Bio-actives and Phytochemicals

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To explore sources, functions, and interactions of micronutrients, including phytonutrients and other orthomolecular compounds in the	3a.3.1	Discuss factors affecting individual requirements for micronutrients, including phytonutrients, and other And other beneficial compounds in foods.	CNH1 KU4, KU15 CNH8 KU39 CNH8. KU44, 48	All	All	All
context of the individual's dietary requirements, therapeutic	3a.3.2	Discuss bioavailability of micronutrients and other beneficial compounds in foods.	CNH8 KU 23, 28,30			
considerations, range of assessment methods and safety.	3a.3.3	Explain cellular functions and interactions of micronutrients and other beneficial compounds in foods.	CNH2 PC1 CNH8 23, 28,30			
	3a.3.4	Explain signs and symptoms associated with micronutrient/ orthomolecular compound deficiency, imbalance and toxicity.	CNH2 PC1,CNH8 2, 13,53			
	3a.3.5	Describe the main categories of phytonutrients, their occurrence and their physiological actions and potential toxicity.	CNH8 KU2,13,53			
	3a.3.6	Compare and contrast different methods used for the assessment of micronutrient and orthomolecular status.	CNH2 KU 2, CNH8 KU10,17,20,25			
	3a.3.7	Explore and evaluate the evidence for the traditional and novel uses of nutrients and non-nutritive substances	CNH8 KU42			

3a.4 Pharmacology

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To understand the principles of pharmacokinetics, pharmacodynamics	3a.3.1	Explain general mechanisms of action, possible side effects including induced nutrient deficiencies and contraindications of commonly used drugs.	CNH9 KU1,2,5,12,21			
	3a.3.2	Describe the factors affecting variability of responses to drugs, and nutraceuticals including genetic influence, age, gender, health status.	CNH8 CNH9 KU3,11,12, 13, 19, 16, 21			
	3a.3.3	Evaluate evidence underpinning information on drug nutrient interactions	CNH9 CNH8 KU29 KU3,4,6, 7 15, 22, 23			
	3a.3.4	Evaluate evidence underpinning information on drug nutrient interactions	CNH9 KU 6,7,9			
	3a.3.5	Explore and evaluate factors to consider when selecting nutraceuticals that may be appropriate for individuals.	CHN8 KU57,58,60 CNH9 KU12,14	All	All	All

3a.5 Pathophysiology

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To provide a systemic, integrated explanation of the common diseases, their aetiology, clinical features and differential diagnosis.	3a.5.1	Explain the process of cell growth, tissue injury, inflammation and repair.	CNH8 KU51,55			
To introduce the value and skill of researching information in practice.	3a.5.2	Discuss core clinical imbalances underlying common disease conditions including the use of appropriate medical terminology.	CNH8 KU52, 54,59			
	3a.5.3	Recognise and discuss the clinical signs and symptoms generated by the body's response to internal and external influences.	CNH8 KU53,60.2			
	3a.5.4	Discuss factors that may affect requirements, including for example the impact of genetics, disease, bioavailability, absorption, transport and metabolism.	CNH8 KU39			
	3a.5.5	Explore and evaluate how microbiota can impact on health	CNH8 KU56	All	All	All

3a.6 Food composition

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To explore applied food chemistry and the factors which can affect food from farm to fork.	3a.6.1	Describe the classification of foods	CNH8 KU44,45			
	3a.6.2	Discuss energy balance in relationship to food intake and expenditure.	CNH8 KU 43			
	3a.6.3	Discuss factors affecting nutrient bioavailability.	CNH8 KU30,46			
	3a.6.4	Evaluate the use of food composition tables and nutritional databases in determining the nutrient content of food.	CNH8 KU17,45			
	3a.6.5	Evaluate dietary reference values.	CNH8 KU 43			
	3a.6.6	Discuss sources of food toxins, possible food safety concerns and adverse reactions to foods.	CNH8 KU 49			
	3a.6.7	Discuss the regulations governing food from farm to fork, and the effects of production, processing and preparation on food quality, health and the environment	CNH8 KU47	All	All	All

3a.7 Diet and Health

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To develop the skill of using food as therapy.	3a.8.1	Discuss factors affecting food choice and how different cultures describe effects of food on health	CNH8 KU23, 25, 50	All	All	All
	3a.8.2	Describe dietary requirements through the life stages.	CNH8 KU28,43			
	3a.8.3	Critique dietary models and use of therapeutic foods in relation to prevention and modulation of functional status and understand how to balance the diet to achieve negotiated goals, redress deficiency and optimize functional status or provide palliative care.	CNH8 KU13,16, 26 CNH9 KU10			
	3a.8.4	Qualitatively and quantitatively and evaluate food intake using manual or electronic means.	CNH8 KU17,25,45			
	3a.8.5	Construct menu plans which meet negotiated therapeutic goals exploring the uses of transitional, alternative and functional foods, recipes and menu plans to increase compliance. Demonstrate awareness of ethical and environmentally sensitive dietary advice.	CNH8 KU10,18,27			

3a.8 Nutritional Physiology and Therapeutics

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To explore impact of nutrients, from diet and nutraceuticals, in relation to	3a.9.1	Discuss the concept of Nutritional Therapy as a process driven modality	CNH8 KU3,34			
homeodynamics and dysfunction and the application to improve health	3a.9.2	Explain the concepts underpinning CAM, and integrative and orthodox medicine and dietetics	CNH8 KU4, 31,34			
	3a.9.3	Discuss the roles of research in informing clinical decision making	CNH8 KU5, 20			
	3a.9.4	Evaluate assessment methods including functional, anthropometric and nutrigenetic tests	CNH8 KU7,9, 26, 57,58			
	3a.9.5	Discuss nutrient modulation of metabolic, physiological and behavioural function including detoxification	CNH8 KU 32,33 , CHN9 KU 14			
	3a.9.6	Discuss nutritional management of malnutrition, eating disorders and obesity.	CNH8 KU 26 CNH9 KU11			
	3a.9.7	Discuss impact of stress on nutrient status and nutrient modulation of the HPA axis.	CNH8 KU, 48, 52,53, CHN9 U12			
	3a.9.8	Evaluate how to prescribe nutraceuticals ethically, cost effectively and with regard to the environment and personal circumstances of the individual.	CNH8 CHN9 KU15, 17,30	All	All	All

Section 3b Clinic

3b.1 Clinical Practice Management and Consultation

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To have a full understanding of the ethical, administrative, legal and business environment in which the health care practitioner must operate.	3b.1.1	Describe relevant codes of conduct and requirements for student, associate and full members of the professional registering body.	CNH1 KU13 CNH2 KU11 CNHN8 PC7			
	3b.1.2	Discuss issues of time management that enhance or detract from good client practitioner relationships.	CNH1 KU1,2,10 CNH2 KU10 CNH8 PC8			
	3b.1.3	Discuss boundary setting within the practice of integrated health and duty of care as it may apply to their practice and client	CNH2 KU11 CNH8 KU36 PC7			
	3b.1.4	Determine requirements for managing client records, documentation and finances.	CNH1 KU1,2,16 CNH2 KU11 CNH8 KU37			
	3b.1.5	Discuss legislation relevant to practice and the law, procedures and requirements pertaining to client confidentiality.	CNH8 PC7			
	3b.1.6	Discuss the roles and functions of other health service providers both in their own field and those from which their clients may seek assistance	CNH2 KU3, 4,5,7CNH8 KU11,31			
	3b.1.7	Evaluate how and when to provide additional information to a client and when it is appropriate to refer the client to another practitioner. This includes awareness of boundaries to practice in high –penetrance single gene disorders.	CHN2 KU3, 5,7 CNH8 KU31			
	3b.1.8	Discuss the meaning of implied and informed consent and the procedures for obtaining consent to therapeutic treatment as well as the circumstances under which written consent should be obtained.	CNH8 KU8	All	All	All

3b.2 Clinical Practitioner Development and Consultation

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To explore and practice the skills required to build a	3b.2.1	Discuss the historical development of the therapy and the profession nutritional therapy principles and philosophy	CNH8 KU CNH9 KU			
beneficial therapeutic and professional relationship.	3b.2.2	Explore means of verbal and non-verbal communication in the context of the practice setting and methods of encouraging and empowering the client to be as actively involved as possible	CNH2 KU5,6,9 CNH8 KU35,36 PC4			
To explore and utilise methods for reflection -	3b.2.3	Identify and manage restrictions to effective communication.	CNH1 KU7 CNH2 KU5, 8,9 CHN8 KU22,23,35			
developing the practitioner as a life-long learner	3b.2.4a	Discuss the complex nature of the client-practitioner relationship.	CNH1 KU3,4,5,6,7,8,9,10,			
	3b.2.4b	Identify inaccuracies in client information and clarify these inconsistencies with the client.	CNH2 KU1,2,3,6,7,8,9,10. CNH8 KU12 KU22,23			
Develop strategies for self-development.	3b.2.5	Demonstrate models of reflection and how these are applied to practice and using reflective skills to produce an action plan for personal development.	CNH8 KU21			
	3b.2.6	Demonstrate values appropriate for ethical working in clinical and interprofessional environs.	CNH1 KU11,12,13,14			
	3b.2.7	Develop evidence based rationale for proposed nutritional advice	CNH2 KU1, 2,3 all of CNH8 and CNH9			
	3b.2.8	Demonstrate the ability to systematically locate, review and evaluate research evidence.	All of CNH1, CNH2, CNH8 CHN9			
	3b.2.9	Develop and use protocols for interfacing with other health care providers.	CNH1 KU13 CNH2 KU2,3,4 CNH8 KU11			
	3b.2.10	Demonstrate how to respond to conflicting advice which clients may receive from different sources.	CNH1 KU3,12 14 CNH8 KU11			
	3b.2.11	Demonstrate the importance of presenting a professional environment and manner	all of CNH1 CNH2			
	3b.2.12	Discuss the application of client centered and integrated approaches to NT practice and relevance of red flags	CNH8 KU2, 13, 60.1	All	All	All

3b.3 Clinical Practice Consultation

Aims	No.	On successful completion of the programme the student will be able to:	NOS	SEEC	HE L4	HE L5
To develop Nutritional Therapy skills to assess,	3b.3.1	To ensure environment is suitable, equipment is ready and client comfortable and safe.				
educate and evaluate the client needs, using the	3b.3.2	Explain the Nutritional Therapy approach to the client and the limitations and potential risks of the therapy.				
appropriate range of understanding and	3b.3.3	Encourage the client to set goals ask relevant questions, seek advice or express concerns.				
knowledge from all of the	3b.3.4	Design and implement appropriate health questionnaire		All	All	All
NOS CNH1, CNH2, CNH8	3b.3.5	Discuss holism, balance and good health and functional status				
and CNH9	3b.3.6	Identify possible serious health conditions/red flags and situations where NT is not appropriate and refer appropriately.	CNH1 CNH2			
	3b.3.7	Explain the importance of negotiating assessment and therapy.				
	3b.3.8	Describe strategies to ensure client understanding of their role and responsibilities throughout the therapy process.	CNH8			
	3b.3.10	Critically review effectiveness of therapy using an outcome measure, for example, MYMOP system with the client and make appropriate changes to the protocol with explanation.	CNH9			

The MYMOP2 questionnaire is suggested as a useful tool for use in the evaluation of treatment outcome. Appendix III

Appendices

Red Flags

Transferable skills

MYMOP

Definitions

Appendix I

Red Flag List Symptoms

pain any pain which is persistent, particularly if severe or in the head, abdomen or central chest

pain in the eye or temples, with local tenderness, in the elderly, rheumatic patient pain on passing urine in a man cystitis recurring more than three times in a woman

absence of pain in ulcers, fissures etc.

sciatic pain if associated with objective neurological deficit **bleeding** blood in sputum, vomit, urine or stools vomit containing "coffee grounds" (coagulated blood, twisted bowel)

black, tarry stools (cancer)

non-menstrual vaginal bleeding (intermenstrual, postmenopausal, or at any time in pregnancy) *vaginal bleeding with pain in pregnancy or after missing one period

psychological deep depression with suicidal ideas hearing voices incongruous behaviour

persistent vomiting &/or diarrhoea delusional beliefs

*vomiting &/or diarrhoea in infant thirst increase in passing urine

cough

unexplained loss of weight (1lb per week or more)

sudden *breathlessness

*breathing

change in bowel habit

*swelling of face, lips, tongue or throat *blueness of the lips

*loss of consciousness

*loss of vision

*convulsions

unexplained behavioural change

difficulty swallowing

in a skin lesion (size, shape, colour, bleeding, itching, pain)

others pallor

unexplained swelling or lumps

*neck stiffness in a patient with fever

unexplained fever, particularly if persistent or recurrent brown patches (Addison’s disease)

Appendix II

Transferable skill

The QAA requires that study skills, often called transferable skills, are embedded in programmes. These are:

1. Communicate with others in a clear and articulate manner, using word or number, through written work using appropriate academic conventions.
2. Present ideas and arguments verbally in formal presentation and seminars and informal discussions in a variety of environments.
3. Work with others in the preparation and presentation of group work and take responsibility for an agreed area of shared activity.
4. Negotiate informally with peers and formally with members of organisations.
5. Identify and propose solutions to problems both in relation to the substantive area of health studies and for other educational and social issues.
6. Recognise issues relating to equal opportunities and identify appropriate action in relation to such issues.
7. Use information technology to store, retrieve and produce material for health studies, course work, drawing on skills in the use of word-processing, databases and spreadsheets as appropriate to the task.
8. Gather and analyse relevant information from a wide variety of sources using appropriate manual and electronic sources.
9. Reflect on and review progress in their own studies and seek assistance or guidance as appropriate in order to enhance their own personal development.

Appendix III

The Measure yourself Medical outcome Profile (MYMOP)

The MYMOP questionnaires and user pack can be downloaded from the Framework for measuring impact at this address

http://www.measuringimpact.org/s4-mymop2

Appendix IV

Definitions

Definitions of words used in nutritional Therapy Standards have been copied

Advice

Advice, where the practitioner offers recommendations as to what the client should do, is in contrast to providing information where the client is given facts and data so that they can decide their possible courses of action. Advice may be available from others or developed by practitioners themselves.

Anthropometric tests

Height, weight, body mass, body fat percentage, body water content.

Assessment

Evaluation of all the known information about a situation or person, a judgement of the position and what is likely to happen i.e. the collection and evaluation of information and a subsequent judgement.

Audit

A systematic examination to assess the effectiveness or otherwise of actions/ processes. Audits may focus on different aspects of services and include clinical audits, quality audits and financial audits.

Body systems

Mechanisms that the whole body uses for functional status.

Clinical supervision

A supportive and structured framework in which the therapist is able to discuss issues with their peer or senior therapist to ensure the client is given the best possible therapy.

Code of Ethics

Guidelines laid down by the professional body which defines standards of behaviour and values for practitioners.

Consent

Consent may be informed or implied. Implied consent is that which is not explicitly sought or expressed by the client. Informed consent is that where the client has all relevant information and the necessary understanding to decide whether the course of action is the right one or not for them.

Continuing professional development

Means by which the practitioner maintains his/her current level of expertise in line with best practice, and develops this further to extend his/her skills and understanding. For qualified practitioners of nutritional therapy, professional development could include further training and/or qualifications in a related discipline e.g. herbalism

Contract

All agreements between practitioners and clients, be they formal or informal, written or oral. Contracts will cover the roles and responsibilities of both parties.

Contra-indications

Factors which indicate that a particular treatment, procedure or material is unsuitable for a client.

Diagnostic Testing Procedures

Non-Invasive testing Anthropometric testing Biochemical testing

Effectiveness

The effectiveness of activities and interventions is the extent to which they achieve their intended objectives and benefit the recipients, correctly, safely and consistent with current, valid research evidence.

Endogenous

Arising from within or derived from the body e.g. Resulting from metabolic processes.

Exogenous

Originating from outside the body e.g. Resulting from the diet or surrounding environment.

Epidemiological parameters

Gender, age, geographical location, social, familial, genetic, environmental.

Equal Opportunities

Acting, and using language without discrimination e.g. with regard to race, sex, religion, ability, age, culture to ensure that everyone has equal access and treatment as an individual.

Evaluation

Evaluation is the process of determining the effectiveness, value or quality of something based on a careful study of its good and bad features against pre-defined criteria. Evaluation can take place while something is happening and influence what happens next (formative evaluation) or take place at the end (summative evaluation).

Evidence-based practice

Integrates individual expertise with the best available evidence from systematic research to assist in decision making about practice.

Holistic Recognising that health and social well-being should be considered as a whole and in relation to everything that affects a person's life i.e. that component parts should not be considered in isolation from others.

Homeodynamics

Applied to the body, the term describes a range of continuously occurring metabolic and physiological activities that enable an individual to adapt to changing circumstances, stresses and experiences. The homeodynamics of a person's health work behind the scenes, constantly enabling that person to act as a unique individual.

Integumentary

Relating to the skin

Intervention

An intervention is any planned action to influence an outcome in a specific way.

Lifestyle

The habits which people adopt in their daily life including dietary, activity/exercise, social interaction, cultural.

Malnutrition

The state of bad or poor nutrition that may be due to inadequate food intake, imbalance, malabsorption, improper distribution of nutrients increased nutrient requirements, losses, or over-nutrition.

National Occupational Standards

A specification, agreed nationally, of good practice at work. The standard is presented as performance criteria, the scope of circumstances in which performance should be demonstrated, and the knowledge and understanding required. National occupational standards are presented in Units of Competence defined in CNH1, CNH2, CNH8 and CNH9

Nutraceutical

Naturally derived bioactive compounds that are found in foods, dietary supplements and herbal products, and which have health promoting, disease preventing or medicinal properties. This does not include essential nutrients.

Nutritional Therapy:

Dietary and nutriceutical intervention used in the mitigation of a physiological or biochemical disorder, enabling the body to return to a state of optimum function.

Objective

The intended outcome of an intervention.

Orthomolecular

Natural chemical constituent(s) of the body.

Optimise health, functional status & well-being

Enabling people to make the best of their own health, abilities or situation within their own life context.

Patient/Client

Any person who has or believes he/she has less than optimum physiological or biochemical function who seeks to redress this though nutritional therapy.

Pharmaceutical

Any product manufactured by a pharmaceutical company to include any drug which is generally prescribed or sold over the pharmacy counter.

Pharmacokinetics

The study of the action of drugs within the body, including the routes and mechanism of absorption, distribution, excretion and metabolism; onset of action; duration of effect; biotransformation; and effects and routes of excretion of the metabolites of the drug.

Pharmacodynamics

The study of how a drug acts on a living organism, including the pharmacologic response and the duration and magnitude of response observed relative to the concentration of the drug at an active site in the organism.

Rationalise

Giving consideration to the reasoning behind all factors surrounding the formulation of a client's treatment protocol.

Red flag list

A list of symptoms which indicate or may indicate serious conditions – listed below.

Research

A detailed, systematic study of a subject or an aspect of a subject which involves collecting and analysing data and information and synthesising these in new ways to generate new knowledge and understanding, or new approaches which have general application.

Training Providers

Any institution or organisation which seeks to provide education and training in nutritional therapy which has or wishes to seek course approval from one of the registering bodies under the NTEC.

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Miguel Toribio-Mateas
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Chair: Anna van der Gaag
Chief Executive and Registrar: Marc Seale

1 October 2014

Dear Mr Toribio-Mateas

I am writing in response to your letter and enclosures dated 4 September 2014.

Firstly, I wanted to acknowledge the considerable time and effort that has gone into putting together the documentation you sent to me and your desire and aspiration to see the statutory regulation of the nutritional therapy profession.

Having considered your formal request, I have responded below in two parts. Firstly, I have outlined our view on the legal basis for the request outlined on page five of the documents you sent. Secondly, I have outlined the current policy context which informs existing Government policy on the regulation of further professions.

'Legal basis for the request'

We understand that your request in summary is to extend statutory regulation by the Health and Care Professions Council (HCPC) to nutritional therapists by means of a 'parts and entries' order made under Article 6 of the Health and Social Work Professions Order 2001 ('the Order').

Whilst it is correct that Article 6 of the Order gives the Privy Council powers to divide the HCPC register into such parts as the Privy Council may by order determine, that power must be construed based upon the whole Order and, in particular, Article 5.

Article 5(1) requires the HCPC, in accordance with the provisions of the Order, to "establish and maintain a register of members of the relevant professions."

The "relevant professions" are defined in the Order as the 16 professions which HCPC regulates, either because they were included in the Order when it was first made or as it has been amended by orders made under Section 60 of the Health Act 1999 or through primary legislation.

The legislative intent of Article 6 is to enable to Privy Council to organise the HCPC register on a logical basis for the relevant professions and, where necessary, to make changes which reflect changes in a relevant profession (such as a profession sub-dividing into distinct specialisms). In our view, Article 6 was never intended to be a means by which a new profession could be added to the HCPC register. That requires either a Section 60 Order under the Health Act 1999 or primary legislation. We consider that what the British Association for Applied Nutrition and Nutritional Therapy (BANT) is asking the Privy Council and the HCPC to do would be ultra vires.

The policy context informing extension of statutory regulation

The above explains our understanding of the legal position. However, we make no comment on the substance of the nutritional therapy profession's case for statutory regulation, nor on the merits of otherwise of a 'single statutory register' for professionals working in nutrition.

Decisions about whether further professions, including your own, should be brought into statutory regulation are for Ministers, and not for the HCPC. As outlined above, the regulation of a new group requires a Section 60 Order under the Health Act 1999, which has to be approved in both the UK and Scottish parliaments. I understand from your letter than you have already copied your submission to the Secretary of State for Health.

You will be aware that in 2011, the current UK Government published the Command Paper 'Enabling excellence' which set out its policy on the regulation of health and care professionals. This paper set out the Government's preference for a system of 'voluntary assured registration' whereby voluntary registers of health and care professionals, normally held by professional bodies, would be accredited by the Professional Standards Authority (PSA). You mention in your submission that the Complementary and Natural Healthcare Council has been accredited by the PSA and holds a register of nutritional therapists.

With reference to future statutory regulation, the Command Paper said the following.

> 'The extension of statutory regulation to currently unregulated professional or occupational groups...will only be considered where there is a compelling case on the basis of a public safety risk and where assured voluntary registers are not considered sufficient to manage this risk.' (paragraph 4.12)

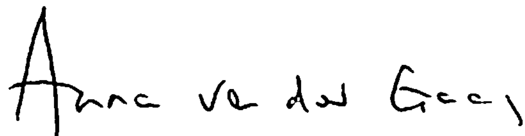
We understand that the above continues to reflect government policy on the extension of statutory regulation at this point in time.

You ask that your request is considered at the HCPC's next Council meeting on 24 September 2014. However, as I have outlined above, we consider that your request is based upon a flawed interpretation of the relevant legislation. Consequently, I do not propose to put this matter before the Council.

I understand that your submission was sent or copied to the Department of Health, the Privy Council and to the British Dietetic Association. I have therefore copied this letter to those organisations.

I hope this letter is helpful in setting out the current position.

Yours sincerely,



Anna van der Gaag
Chair

cc. Sue McGinty, Policy Director, British Association for Applied Nutrition and Nutritional Therapy
cc. Chris Harris, Professional Standards, Department of Health
cc. Ceri King, Head of Secretariat and Senior Clerk, Privy Council
cc. Andy Burman, Chief Executive, British Dietetic Association

BANT®
British Association for Applied Nutrition & Nutritional Therapy

14 October, 2014

By First Class Post

Dr Anna van der Gaag
Chair of the Health and Care Professions Council
Park House
184 Kennington Park Road
London SE11 4BU

Dear Dr van der Gaag

Formal Request to Modify the Statutory Register for Dietitians

We refer to your letter of 1 October 2014, which we received on 3 October 2014 ("Letter") responding to our request for modification of the statutory register for dietitians ("Request"). Your Letter responds to our Request in two parts: (1) the legal basis for the Request; and (2) the policy context informing the extension of statutory regulation. With the greatest respect, part (2) is irrelevant to our Request. This is because the Request does not seek the establishment of a new register for nutritional therapists. We fully appreciate that the establishment of a completely new statutory register would require an Order in Council pursuant to Section 60(1)(b) of the Health Act 1999 ("Act").

Rather, the Request seeks modification of the existing register for dietitians to allow entry for nutritional therapists. The HCPC plainly has the power to modify the register of dietitians under Regulation 6 of The Health and Social Work Professions Order 2001 ("2001 Order", see section 1 of the Request).[1] Section 3 of our Request sets out what we believe is the key modification required under Regulation 6 of the 2001 Order to allow entry to the register. Essentially, we consider that nutritional therapy practitioners meet all the HCPC Standards of Proficiency for Dietitians (2013) except for those that relate to acute nutrition and withholding/withdrawal of nutrition. This area of practice is confined to the NHS setting and therefore outside the nutritional therapy scope. Neither is acute (parenteral/enteral) nutrition discrete dietetic practice since critical care nurses, gastroenterologists and others also participate. For that reason, BANT submits that the acute scope of practice is a specialist area of practice and should be removed as a pre-requisite for registration as a dietitian.

We would greatly appreciate it if you could re-consider your position on the legal basis in light of our clarifying comments above. We would appreciate your response within the next 14 days. We reserve all of our legal rights in that regard, including the right to judicially review the Letter.

Yours sincerely

Miguel Toribio-Mateas
BANT Chair

cc. Ceri King, Privy Council

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[1] The HCPC will be aware that we have made a similar request to the Privy Council, which has its own independent power to make such modifications under Regulation 6 of the 2001 Order and also under Section 60(1)(a) of the Act.

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Chair: Anna van der Gaag
Chief Executive and Registrar: Marc Seale

4 November 2014

Dear Mr Toribio-Mateas

Regulation of nutritional therapists

I am writing in response to your letter of 14 October 2104 concerning BANT's proposals for the regulation of nutritional therapists.

As your letter concludes with the rather hostile comment that BANT reserves "all of our legal rights in that regard, including the right to judicially review the Letter" (i.e. our letter of 1 October 2014), I will reiterate our understanding of the relevant law:

- The power to make an order under Article 6(1) or (3) of the Health and Social Work Professions Order 2001 (the **2001 Order**) is one which can only be exercised by the Privy Council. Thus, the HCPC has no power to make such an order.

- That power enables the Privy Council, by order, to divide "the register" (which is defined to mean the register established and maintained under Article 5 of the 2001 Order) into parts so that it is organised on a logical basis, to annotate it and, where necessary, to re-organise it to reflect changes in a relevant profession (such as a profession sub-dividing into distinct specialisms).

- Like any other statutory powers, Articles 6(1) and (3) must be construed by reference to the relevant enactment as a whole and, in our view, having particular regard to Article 5(1) of the 2001 Order, which requires the HCPC to establish and maintain a register of members of "the relevant professions".

- As the "relevant professions" are defined within the 2001 Order, we consider that the powers in Articles 6(1) and (3) were never intended to be used by the Privy Council as a means to bring a new profession within the ambit of statutory regulation by the HCPC. By a new profession we mean any group that was not within the contemplation of Parliament when a relevant profession was first regulated (other than a group which has been created as a result of the development of one of those professions).

- As regulation of a new profession by the HCPC requires either a 'Section 60 Order' made under the Health Act 1999 or primary legislation, we consider that it would be *ultra vires* for the Privy Council to use the powers under Articles 6(1) or (3) of the 2001 Order in the manner which has been suggested and, consequently, that it would be improper for the HCPC to suggest that the Privy Council do so.

In your letter you suggest that BANT is not seeking the regulation of a new profession but the "modification of the existing register for dietitians to allow entry for nutritional therapists.". You then go on to state that "The HCPC plainly has the power to modify the register of dietitians under Regulation 6 of The Health and Social Work Professions Order 2001".

Dealing with the latter point first, as I believe has already been made clear, the HCPC does not have that power; making an order under Article 6(1) or (3) of the 2001 Order is a power which can only be exercised by the Privy Council.

Turning to your first point, by your own admission nutritional therapists do not meet the Standards of Proficiency for admission to the dietitians part of the HCPC register.

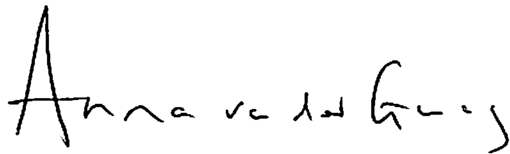
In particular, the Standards which you acknowledge that nutritional therapists could not meet are those relating to acute nutrition and the withholding or withdrawal of nutrition. As these aspects of acute and critical care are beyond the scope of nutritional therapy, you suggest that the remedy would be to remove these Standards from the dietitians' Standards of Proficiency so that nutritional therapists could then register as dietitians.

The HCPC cannot vary the Standards of Proficiency simply to accommodate the aspirations of an unregulated profession. Article 5(2) of the 2001 Order requires the HCPC to establish Standards of Proficiency for the professions it regulates at a standard which it considers to be "necessary for safe and effective practice". Before doing so, it must consult in accordance with Article 3(14) of that Order and must take account of its functions and objectives, as set out in Article 3 of that Order, including having proper regard for the persons using or needing the services of registrants.

The HCPC Standards of Proficiency for dietitians were last reviewed in March 2013 and at no time - either during that or any previous review - has it been suggested to us that the Standards relating to acute nutrition and the withholding or withdrawal of nutrition should be removed from the Standards of Proficiency on the basis that they are specialist post-registration skills which are not necessary for safe and effective dietetics practice.

Obviously, it would have been open to BANT to advance that argument during the most recent consultation on the Standards of Proficiency, but any such argument would need to have been supported by evidence that these Standards are not necessary for safe and effective dietetics practice. To date, the only evidence provided by BANT is that its members cannot meet those standards.

Yours sincerely,



Anna van der Gaag
Chair

cc. Sue McGinty, Policy Director, British Association for Applied Nutrition and Nutritional Therapy
cc. Chris Harris, Professional Standards, Department of Health
cc. Ceri King, Head of Secretariat and Senior Clerk, Privy Council