Tackling undernutrition through integrative care and taking responsibility

Reducing undernutrition in older people

Malnutrition (undernutrition) affects three million people in the UK (Brotherton et al, 2010) and is responsible for health and social care costs exceeding £19 billion annually in England alone, half of which is due to people over 65 (Elia, 2015). While it is accepted that good nutrition is important to maintain health, there is a general lack of responsibility and ownership around the problem of undernutrition in primary care. Lack of understanding, including how to identify and treat it is also widespread. Despite National Institute for Health and Care Excellence (NICE) guidelines stating that all healthcare professionals should be involved in nutritional screening and treatment (NICE, 2006), there are barriers stopping primary care nurses from screening, i.e. challenges of organisational culture and competing priorities (Green and James, 2013; Green et al, 2014).

The Nutrition in Older People Programme, delivered by the Wessex Academic Health Science Network (Wessex AHSN; http://bit.ly/2lpNWrD), was developed to focus on the issue of undernutrition in the community and to evaluate new and innovative approaches to reduce this problem.

The programme's two major projects to date are the Dorset malnutrition project and the OPEN (Older People's Essential Nutrition) project, both of which have led to other innovations and research.

DORSET MALNUTRITION PROJECT

In 2014, Dorset launched its initial pilot scheme to tackle undernutrition, which involved implementing nutritional care pathways for health and social care teams in the community linked to a single GP practice in Purbeck. This included developing and piloting an electronic form to record screening results. Following the success of this pilot, the initiative was rolled out across five other local GP practices in 2015 with the support of the Wessex AHSN. In early 2016, the project was extended into the Christchurch locality, involving a total of 13 GP practices. Positive outcomes from these projects have led to this integrated approach for community-based undernutrition screening and care being rolled out across the whole of Dorset.

Data from the 20-month pilot in Purbeck found that 561 people were screened for undernutrition using the Malnutrition Universal Screening Tool ('MUST'), which identifies whether people are 'at risk' of undernutrition (http://bit.ly/1S2AesJ), of which 27% were found to be 'at risk'. Seventy-five percent of these people were screened by teams who were not screening before the intervention, e.g. social care.

OPEN PROJECT

In 2014, it was agreed to pilot a new integrated approach following the NICE guidelines for nutritional support with the aim of reducing undernutrition in Eastleigh, Hampshire. The location for the 'OPEN Eastleigh project' was chosen due to existing local links with clinical and academic expertise, and the initial interest and commitment from Hampshire County Council and West Hampshire clinical commissioning group (CCG). Development of resources and staff training (for health and social care teams and one pilot local authority care home) was carried out in early to mid-2015, with additional awareness training provided to local voluntary sector organisations and community pharmacies. In total, 190 staff members were trained (representing over 80% of the health and social care workforce in the pilot area). Undernutrition screening data (using 'MUST') and wellbeing data were collected by staff for a 12-month period (May 2015 to April 2016), along with regular support being available by a dietitian. In total, 375 people were screened at least once (61 people were screened more than once, of which 51% had improved nutritional status reflected by decreased 'MUST' score and/or increased weight). Several screenings were done by teams not previously screening, and those previously screening were doing so more effectively by the end of the pilot.

The main challenge for this project was demonstrating a true integrated approach. While commitment from teams was obtained in the early stages, issues including management changes, other clinical priorities taking precedence, staff adapting and accepting new roles, and difficulty sharing information between teams influenced the success of the project.

A key outcome from this project has been the development of the OPEN Toolkit. Developed and tested using a multidisciplinary approach, this includes training materials (e.g. session plans, PowerPoint

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presentations and case studies) specific to different roles, generic nutritional care pathways (which can be localised), an evaluation framework, hydration toolkit, awareness posters and a patient information leaflet.

NEXT STEPS

Over the past nine months, the Wessex AHSN has initiated and supported a variety of projects, including:

- Working with voluntary sector organisations (e.g. Age Concern Hampshire) to look at simple screening methods and signposting for older people in the community
- Working with care agencies to build nutritional screening and advice into assessment procedures
- Having a volunteer in a GP practice to screen patients with the aim of assessing whether volunteers have a role to support screening, as well as determine the number of people 'at risk' of undernutrition.

WORKING WITH GENERAL PRACTICE NURSES

It became apparent from the OPEN Eastleigh project that there were several barriers to screening in general practice. This is a concern because while untrained staff and volunteers can signpost to services to support a patient's social situation, current guidance usually directs patients to make an appointment with their GP or general practice nurse (GPN) if there are any medical causes of concern, or to discuss nutritional needs further.

Thus, the Wessex AHSN carried out an online survey (sent to 204 GPNs) followed by attendance at three GPN forums to follow this up (which engaged 41 GPNs). A total of 32 responses were received from the online survey (16% response rate), and while small in number, results were consistent with those found at the forums and indicated that:

- 81% of GPNs were concerned about undernutrition
- 75% felt that they should be screening for undernutrition
- 87% had not received any recent training on malnutrition/screening
- 9% were currently screening using 'MUST' (*ad hoc* basis only)
- The main barriers to screening included lack of time, training, and knowledge of the actions to take if the patient had a raised 'MUST' score.

Forum discussions revealed that the issue of 'lack of time' was related to the time involved in providing nutrition advice and support during assessment and follow-up, rather than the time required for screening. Other issues raised in the forum, included; lack of financial incentive to follow up 'at-risk' patients, lack of support from GPs, and the perception that 'at-risk' patients are seen at home rather than coming into the practice.

The Wessex AHSN is now looking at ways to engage GPNs and GPs, as well as supporting the CCG to provide appropriate awareness channels.

CONCLUSION

From the lessons learned so far, there appear to be several keys in establishing a true integrated system. It is clear that buy-in and commitment from senior management is of paramount importance, with the ownership coming from within the organisations and teams themselves, rather than an outside organisation providing the direction and impetus. Undernutrition remains an issue where everyone is responsible, yet no one has the overall responsibility for it within primary care.

It is also clear that there is still a lack of knowledge and confidence in the timely identification and treatment of undernutrition. In particular, further training is required around appropriate care planning and advice for people with different 'MUST' scores, e.g. the difference between the early identification of people 'at risk' from starting to lose weight, and those who have become underweight due to continued weight loss, who may therefore require more intensive treatment.

While there is still limited evidence to support the usefulness and effectiveness of volunteers in providing basic nutrition assessment, advice and signposting, this appears a promising area to investigate further. Initial results suggest that there is value in investigating and evaluating simpler methods of screening for undernutrition.

With a combination of all the work being done by the Wessex AHSN and other organisations around the UK, such as Age UK and the British Association for Parenteral and Enteral Nutrition (BAPEN), and the willingness for teams to take ownership of the issue, the prevalence of undernutrition can be reduced. However, it is important to consider the time needed for changes to become embedded in normal practice, which includes a culture change both for healthcare professionals (e.g. screening, raising awareness and giving appropriate advice) and older people themselves (e.g. to realise that losing weight is not a normal part of the ageing process, and the change from 'traditional' healthy eating messages, as depicted in the Eatwell Guide [Public Health England, 2016]). **GPN**

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