Wessex Academic Health Science Network

Project Report: Training
Older Peoples Essential Nutrition (OPEN), Eastleigh

Contents

Executive Summary

Whilst many projects have been done to evaluate 'MUST' training in the community, the OPEN project considered malnutrition awareness training across a range of different teams and sectors (spanning healthcare, social care and the voluntary sector) in a defined geographical area where no specific input around reducing malnutrition had been previously been received by these teams / sectors.

Data from pre-implementation surveys, involving asking questions on current nutrition knowledge and practice (including screening, use of care pathways and individualised care planning), were carried out with the teams at the start of the project. These were compared with post-implementation surveys to reveal an increase in malnutrition awareness and care planning. Data from pre and post training quizzes, follow up work with teams and post-training surveys all indicated that the training provided around malnutrition was effective in raising awareness across all teams and sectors.

Whilst it was not possible to obtain data about whether screening and individualised care planning for malnutrition had increased or was more effective by the end of the project, since the completion of the project, the increased awareness has acted as a springboard to more work around reducing malnutrition in the community in and around the Eastleigh area. This includes staff who were part of the project taking on a more active role in leading work around reducing malnutrition.

Introduction

The OPEN project aims to reduce the number of older people who are malnourished and the associated health and social care use, as well as to evaluate an integrated approach to malnutrition identification and treatment between a range of sectors. The project involved raising awareness of the issues of malnutrition in the community health and social care worker and piloting a support package (comprising of training and awareness materials as well as a locally agreed nutritional care pathway) that can be adopted in other localities, in addition to running awareness sessions for the general public.

This report is one of a series comprising the full evaluation of the OPEN project in Eastleigh. This report considers:

- Evaluation of the pre- and post-implementation surveys (surveys used to determine the extent that teams / sectors were already aware of the issues around malnutrition and implementing nutritional screening and care planning at the start of the project compared at after one year)
- The development of the training packages and resources
- Evaluation of the training planning and delivery provided to health care, social care and the voluntary sector
- Evaluation of the *follow up support* provided to health care, social care and the voluntary sector
- Evaluation of training and events aimed at raising awareness with the general public

Composition of the teams

Figure 1 below shows the names of names of the teams receiving training as part of the project, and a brief outline of the composition and structure of these teams.

Figure 1: *Composition of the teams involved in the project*

Healthcare

- **St Andrews Surgery** – 5 GPs, 1 GP Registrar, 3 Practice Nurses (PN)
- **Parkside Practice** – 6 GPs, 3 PNs
- **Boyatt Wood Surgery** – 3 GPs, 1 PN
- **Community Care Team (CCT) -** 15 staff; nurses, higher grade health care assistants, small therapy team
- **Older People's Mental Health team (OMPH)** - 17 staff; nurses, support workers and other clinicians

Social Care

3 teams make up Adult Social Services; part of Hampshire County Council:

- 18 social workers
- 12 occupational therapists
- 11 staff from the Community Independence Team (CIT)

Fleming House Care Home

Local authority run care home, owned by Hampshire County Council. Employs 70 staff, including a manager, two assistant managers, kitchen staff, carers and nursing staff. The care home accommodates 55 residents and has a nursing and a residential unit

Sainsbury's Pharmacy

Busy community pharmacy inside a popular supermarket in Eastleigh town centre – employs 2 pharmacists and several counter staff

Voluntary Sector – One Community

A charity organisation in Eastleigh aimed at supporting older people. Training also provided to individuals and voluntary organisations affiliated with One Community

Chapter 1:
Pre-implementation practice and evaluation of pre- and post-implementation surveys

Before training any of the teams, pre-implementations surveys were carried out with key staff and team leads to determine current knowledge and practice around malnutrition. This was important to provide baseline data to help determine whether the project had been successful in terms of improving malnutrition knowledge and improving screening practice. Surveys were not carried out with staff at the community pharmacy. It was particularly useful to collect this qualitative information as very limited nutritional screening had been carried out prior to the project, so there was little quantitative data to use as a baseline.

Methods

Data for these surveys was obtained via discussion with a dietitian before the commencement of any training to that team. A total of 14 pre-implementation surveys were completed by the teams / sectors – the majority (12) of which were carried out between February and May 2015 (the remaining two, from St Andrews Practice were carried out in September 2015). 12 of these surveys were carried out as one-to-one discussions, and two were carried out through discussion between the project dietitian and a group of staff during a team meeting (Parkside GPs (four GPs) and Parkside practice nurses (two nurses)).

Post-implementation surveys were requested by the same people where possible, although it is known that at least four of the staff who'd completed the pre-implementation surveys had left or moved on to another role, and so were unable to complete a post-implementation survey on behalf of the team. Where staff were no longer in post, the current team leads were approached to complete the survey instead.

Staff were contacted by email to request completion of a survey and given options for completing the survey either through a face to face discussion, over the phone or by email. In total four staff completed a post-implementation survey (all of whom had previously completed a pre-implementation survey). The post-implementation surveys were carried out in person (through a discussion) for two staff members, and returned by email by the other two. Post-implementation surveys were administered and carried out by a research assistant. The same research assistant then analysed (through identification of themes in each section of the survey and then information about the differences in pre and post practice extracted) both the pre- and post-implementation surveys.

Results

GPs and Practice Nurses

Pre-implementation surveys were completed (either in person or as a group) by a total of nine staff from the following practices, representing 41% of the staff from the three practices:

- GP from St Andrews
- PN from St Andrews
- GP from Boyatt Wood Surgery
- Group of four GPs from Parkside Practice

- Group of two PNs from Parkside Practice

These identified that all three Practices were not screening for malnutrition and were, subsequently, not undertaking any nutritional care planning for malnutrition. The surveys identified that there was no nutritional care pathway for malnutrition in any of the GP Practices (care pathways were later developed as part of the project). Despite having existing awareness developed through West Hampshire CCG, none of the staff mentioned a knowledge of this, and two staff (one PN and one GP) mentioned they currently use 'web mentor' for resources (which provides access to leaflets via Patient.co.uk).

A post-implementation survey was completed by one of the PNs and one GP (both of whom had also completed a pre-implementation survey). The PN reports to now be screening and care planning for malnutrition using 'MUST' infrequently for those patients who 'might be malnourished' (visually). The GP reported very little screening was being carried out, and that this was not routine, due to several barriers. Both reported to be using the OPEN resources along with those published by West Hampshire CCG.

Community Care Team (CCT) and Older People's Mental Health (OPMH)

Analysis of pre-implementation surveys (completed by the CCT and OPMH team leads separately) identified that only the CCT was screening for malnutrition and subsequently completing nutritional care planning for malnutrition. The OPMH team members were not screening for malnutrition or completing nutritional care planning. These surveys identified that there were no community-focused nutritional care pathways for malnutrition in use within Southern Health (care pathways were then developed to use as part of the project). Post-implementation surveys were not completed by CCT or OPMH, however the screening data obtained as part of the project suggest that whilst the CCT are continuing to screen for malnutrition, only one screening was done by OPMH (which was done during a shadowing session with the dietitian).

Social Care

Analysis of pre-implementation surveys (completed by the social care team lead and another social care worker) identified that none of the teams were screening for malnutrition and were subsequently not implementing nutritional care planning for malnutrition. The surveys identified that there were no nutritional care pathways for malnutrition in use within Hampshire County Council (HCC) – these were later developed as part of the project. One post-implementation survey was completed and indicated that social workers have now been trained and have a much improved knowledge of malnutrition. They are screening and implementing the care pathways, however only a small number of older people were screened for malnutrition during the project.

Care Home

Pre-implementation surveys were completed by three staff (the overall manager and two deputy managers). Analysis of pre-questionnaires identified that the care home was already undertaking screening using 'MUST' and carrying out nutrition care planning for their residents (therefore a care pathway was put together as a condensed version of their current local authority policy documents) prior to training. Pre-implementation surveys also revealed that care home staff were aware of the causes, signs and symptoms of malnutrition in elderly residents (existing knowledge may have been supported by attendance at prior HCC-run training).

One post-implementation survey was completed by one of the deputy managers, which revealed that the care home staff have continued screening and now use the care pathways developed as part of the project. Dietary advice is given by trained members of staff and they are raising awareness using OPEN resources for residents and family members.

Voluntary Sector

Both pre and post-implementation surveys were completed by the CEO of One community. The pre-implementation survey revealed that there was little knowledge of malnutrition or guidelines for care pathways. Post-implementation surveys revealed a much improved knowledge of malnutrition, and that whilst they are not carrying out screening (screening was not covered in the voluntary sector training awareness sessions anyway), there are plans to screen as part the next stages of the Nutrition Programme. They report to be raising awareness and using project materials at community events.

Chapter 2:
Development of training packages & resources

A Task to Finish group was set up prior the commencement of the OPEN Eastleigh launch. The group (which was made up of representatives from local dietetic departments, local nurses, Health Education Wessex, a local university and the Wessex AHSN) met up regularly to discuss the development of training packages, shared existing departmental training resources, and to discuss the development of malnutrition awareness resources which would be suitable for the general public. A freelance dietitian was employed on a short term basis to a) bring together and review existing resources, b) develop initial training packages, c) draft the contents of an awareness leaflet and d) draft an awareness poster around signs of malnutrition.

Training packages

Training packages (including presentations, training activities and resources) were piloted throughout the project, and amended / updated as needed, following evaluation and review. The final training packages were made available for comments and feedback by the Task to Finish group prior to being finalised and uploaded to the Wessex AHSN website in April 2016. Training packages have been published for the following seven teams / sectors:

1. GPs
2. Practice Nurses
3. Community Nursing
4. Social Care
5. Care Home
6. Community pharmacy
7. Voluntary sector

The following materials have been developed for each team/sector:

- Evaluation forms (pre and post session quiz, and a session evaluation form)
- Trainer notes for the pre and post session quiz
- Session plan
- PowerPoint presentation slides
- Consolidation case studies or discussion scenarios

Additional materials have been produced specific to the audience, e.g. training materials on how to have an effective conversation about eating was included in the voluntary sector and pharmacy training packages, and an activity sheet for caterers was included in the care home training package. BAPEN resources on the Malnutrition Universal Screening Tool ('MUST'), including BMI and weight loss score charts, were used where 'MUST' training was included (community nursing, social care and care home training packages).

OPEN resources

The contents of the awareness leaflet "Eating well, feeling good" (suitable for the general public) were made into a highly visual leaflet with detachable postcards by a graphic designer and

communications team. The contents of the leaflet were reviewed by both the Task to Finish group, and the Programme Steering Group. The leaflet was updated and reprinted in early 2016 to remove the term 'malnutrition' and instead include 'losing weight or underweight', to make it appear less 'clinical'. The leaflet was uploaded to the Wessex AHSN as a downloadable PDF. The original poster (as reviewed by the Task to Finish group, and the Programme Steering Group) was updated by the graphic designer to have the same 'look' and 'feel' as the leaflet, and an additional two posters were created around signs of weight loss, and tips for eating well. These three posters have also been uploaded to the Wessex AHSN website as downloadable PDFs.

Nutritional care pathways

As part of the project, two nutritional care pathways were developed for use with the project in Eastleigh; one for healthcare (GP practices / health component of Integrated Care Team) and one for social work and occupational therapy. These were amended versions of the pathways which were currently being used in Purbeck, Dorset.

The Lead GP and others within the health care sector met with the OPEN team prior to training, in order to jointly develop appropriate nutritional care pathways for the health care sector. Team Leads from Hampshire County Council met with the OPEN team to jointly develop appropriate care pathways for the social care sector. Review of the pre-implementation surveys identified that the care home was currently undertaking screening using 'MUST' and carrying out nutrition care planning for their residents. In view of this, a condensed version of their local authority policy documents was put together for use with the project.

Part of the project also involved genericizing the pathways used in the Eastleigh project to enable them to be used by other teams in areas outside the project area. Three generic care pathways were put together and uploaded to the Wessex AHSN website, along with guidance on how teams / areas could then localise these pathways.

Chapter 3:
Evaluation of training: health, social care & voluntary sector

Methods

Training on malnutrition awareness was provided to GP practices (GPs and PNs from three practices in Eastleigh town centre), community nursing (comprising of the CCT and OPMH), social care, a local-authority care home, a community pharmacy and a range of voluntary sector staff. Length and content of sessions varied between the different teams and sectors, according to the information the teams felt they needed, and input required as determined by the pre-implementation surveys. Table 1 provides a summary of the content, delivery and venues used for the training sessions.

All training sessions involved trainees completing pre- and post-session quizzes to assess knowledge before and after the session. Confidence ratings on using 'MUST' and providing basic dietary advice were also assessed in the relevant teams. All trainees were asked to complete a session evaluation form at the end of the session; this involved trainees completing information about the extent to which they agreed with ten statements (ranging from 'the resources were useful' to 'the slides were easy to read and follow' to 'group participation and interaction were encouraged'. The evaluation forms also asked trainees how they would rate the training overall (options being 'excellent', 'good', 'adequate', 'poor' and 'very poor'. Table 2 in the results section provides a detailed breakdown of the dates training was provided to each team, and the number of staff attending sessions.

Table 1: *Methodology for the delivery of malnutrition awareness training sessions to staff*

Team / sector	Session length	Delivered by	Summary of content	Delivery mode	Venue
GPs	1 hour	Dietitian – face to face	Malnutrition awareness (causes, consequences, identification & treatment), a brief introduction to 'MUST' & the care pathway	Taught presentation, group discussion and a case study	Own GP practice
PNs	2 hours	Dietitian – face to face	More detailed awareness of malnutrition than GP sessions, training on nutritional screening using 'MUST' and care pathway implementation	Taught presentation, group discussion and a case study	Own GP practice
CCT, OPMH & social care	2 hours	Dietitian – face to face	Awareness of malnutrition (including identification, causes, consequences & treatment), training on screening using 'MUST' & use of the care pathways	Taught presentation, group discussion and a case study	Team base
Community pharmacy	1 hour	Dietitian – face to face	Malnutrition awareness, an overview of the nutritional care pathway including dietary advice, signposting, use of OPEN resources, use of the 'tally chart' for monitoring conversations	Taught presentation, group discussion and group activities (consolidation scenarios)	Pharmacy
Care home	2 hours	Dietitian – face to face	Awareness of malnutrition (including identification, causes, consequences & treatment), training on screening using 'MUST' & use of the care pathway	Taught presentation, group discussion, case studies and activity worksheet for caterers	Care home
Voluntary sector	2 hours	Dietitian – face to face	Malnutrition awareness, an overview of nutritional care pathway and dietary advice, signposting, OPEN resources, and having an effective conversation	Taught presentation, group discussion and consolidation scenarios	One Community office

Following training, a survey (via Survey Monkey) was created and distributed by email to 88 members of staff who completed malnutrition training between 11th February and 8th May 2015. The surveys were sent out 2-5 months post-training. Surveys were developed specific to the training sessions and four surveys were developed for the four main staff groups; GPs, nurses (both community and Practice nurses), social care and the voluntary sector. Surveys were not sent to the pharmacy staff due to the small numbers attending training. Each survey consisted of 10 questions (except the GP survey which had only eight), and included a mixture of open-ended and closed questions including whether their practice had changed following the training, use and confidence of using 'MUST' and the nutritional care pathways (where relevant) and to identify any further training needs.

The surveys were analysed according to each individual group, where open ended questions were analysed according to theme and closed questions were analysed according to frequency of the answer. The voluntary sector survey was notably different from the other three surveys; where appropriate the results were analysed with the other three groups but most have been reported separately. The GP, nurse and social care responses were grouped where appropriate.

Results

Number of training sessions and numbers of staff trained from each team / sector

A total of 27 training sessions were delivered to a total of 182 healthcare, social care and voluntary sector staff. Table 2 shows the number of training sessions delivered to each staff group / sector, along with the dates these sessions were run, the number of staff attending vs the number of staff in the team, and the percentage of staff from each team having received training where relevant. As part of the project set-up, a target was set of training at least 80% of staff from each team. This was achieved in all teams with the exception of the care home. However, it's important to note that not all care home staff were going to be carrying out screening, and whilst a range of staff attended (including catering staff), all the staff regularly undertaking screening did attend a training session. Figures 2 and 3 provide this information as pie charts, to show the number and proportion of training sessions provided to each team / sector, and the number and proportion of staff trained from each team / sector. This shows that GPs and Practice nurses received the highest number of training sessions combined whilst being the smallest group in terms of team size. Figure 4 shows the variety of people attending the training sessions aimed at the voluntary sector; of these 10 were staff from One Community, with others from affiliated groups or networks.

Table 2: *Number of malnutrition awareness training sessions provided, dates delivered and number of attendees at sessions. Numbers of staff in teams and percentage of staff receiving training have been provided for teams where this information is available*

Sector	Team	No. training sessions delivered	Dates (No. of staff attending in brackets)	Total No. of attendees from each team / sector	No. staff in team	% of staff receiving training
Healthcare	GPs	6	20.04.15 (2) 20.04.15 (4) 06.05.15 (4) 30.11.15 (1) 06.01.16 (1) 14.01.16 (1)	13	15	87%

	PNs	4*	20.04.15 (1)* 14.04.15 (2) 08.05.15 (2) 18.11.15 (1) 20.11.15 (1)	7	7	100%
	CCT	2	15.04.15 (15) 03.11.15 (11)	12	32	81%
	OPMH			14		
Social care	Social workers	4	25.03.15 (13) 31.03.15 (14) 28.04.15 (8) 20.07.15 (12)	17	41	85%**
	Occupational therapy			11		
	Community independence team			19**		
Community Pharmacy staff		2	15.04.15 (1) Sept 2015 (2)	3	n/a	n/a
Care Home		4	03.06.15 (11) 03.06.15 (14) 09.06.15 (17) 14.12.15 (10)	52	70	74%
Voluntary sector		5	11.02.15 (4) 17.02.15 (6) 18.02.15 (4) 22.04.15 (10) 28.10.15 (10)	34†	n/a	n/a
TOTAL		**27**	-	**182**	-	-

* One practice nurse attended the GP session so not counted as separate training session
** 7 staff from the pilot site; an additional 12 staff attended training from outside the pilot site. 7 staff used in the calculation of percentage of staff attending training
† breakdown of organisations / roles is detailed in chart 3

Figure 2: *The number and percentage of training sessions delivered to each team / sector in the Eastleigh pilot site*

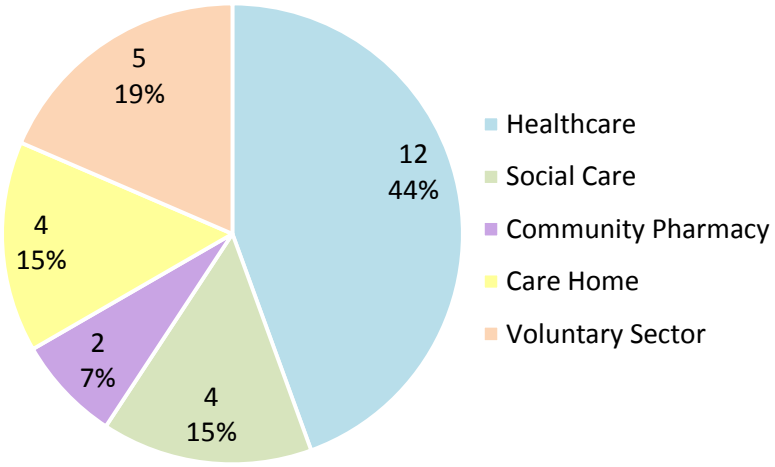


Figure 3: *The number of staff trained from each team / sector in the Eastleigh pilot site (35 staff from social care used in these results, rather than the total number of 47 from social, which included staff from outside the pilot area)*

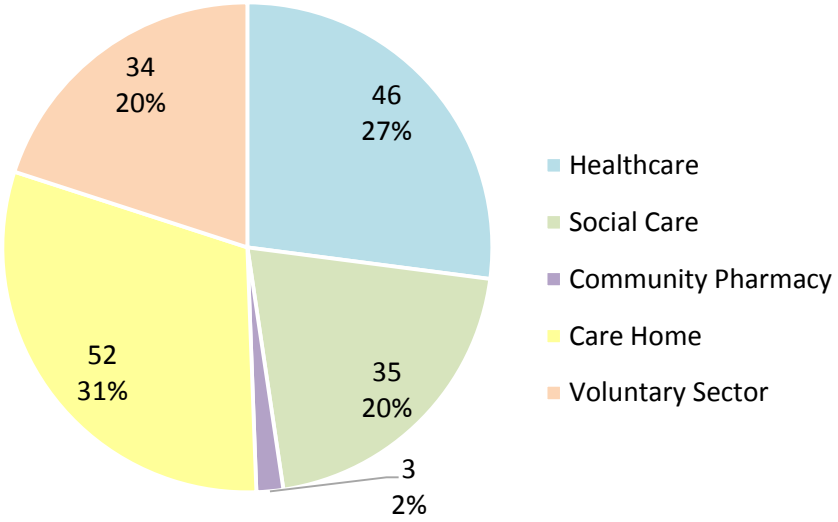
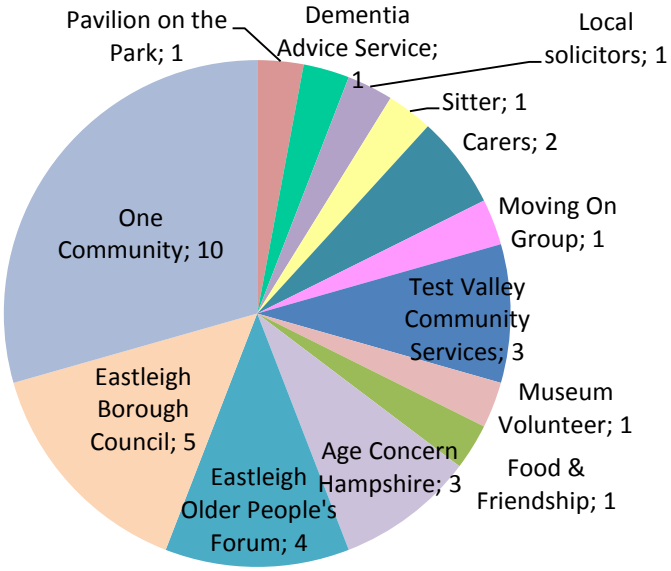


Figure 4: *Staff and organisations attending the voluntary sector training sessions*



Results from pre- and post-session questionnaires

In total, 160 trainees completed both a pre- and post-session quiz, representing 88% of trainees. Data was only analysed for trainees with both a pre- and post-session quiz completed; any trainees who had only completed one quiz were discounted from the data analysis. Not all trainees completed an evaluation form for reasons such as having to leave the session early.

Table 3 shows the results according to team / sector. Not all trainees completed all parts of the quiz, accounting for lower numbers in columns 3-5 than the number of quizzes analysed as shown in column 2. An average increase in knowledge of 19% was seen. Average confidence in using 'MUST' and providing basic dietary advice increased from approximately 5/10 to 7/10 as a result of the sessions. It is very unlikely that trainees would have decreased malnutrition knowledge as a result of attending an awareness session; several issues may account for this decreased figure obtained,

including limitations of data analysis (e.g. data was analysed by a different person to the trainer), phrasing of some of the questions appeared misleading upon reflection, and trainees may have been rushing to get the forms completed so that they could leave the training session promptly.

Table 3: *Analysis of pre and post-session knowledge and confidence quizzes*

Team / sector	No. of quizzes analysed	% with improved knowledge	% with unchanged knowledge	% with decreased knowledge	% average increase in knowledge	Average confidence using 'MUST' (/10)		Average confidence giving dietary advice (/10)	
						Pre	Post	Pre	Post
GPs	12	**57%** (n=4)	14% (n=1)	29% (n=2)	**18%**	3	7	5	7
PNs	7	**29%** (n=2)	14% (n=1)	57% (n=4)	**19%**	5	8	4	7
CCT & OPMH	26	**27%** (n=13)	13% (n=3)	30% (n=7)	**13%**	5	8	6	8
Social care	43	**56%** (n=18)	25% (n=8)	19% (n=6)	**10%**	2	5	3	5
Care home	41	**60%** (n=24)	23% (n=9)	17% (n=7)	**26%**	6	8	6	8
Pharmacy	2	**100%** (n=2)	-	-	**35%**				
Voluntary sector	29	**69%** (n=20)	10% (n=3)	21% (n=6)	**14%**				
Totals & averages	**160**	**57%**	**17%**	**29%**	**19%**	**5**	**7.2**	**4.8**	**7**

Results from post-session evaluation forms

At the end of each session, trainees were asked to complete a session evaluation form. The results of this information were used to confirm the quality of the content and delivery of the training sessions. A total of 152 trainees completed an evaluation form (representing 84% of trainees), with 95% of trainees rating the session as 'good' or 'excellent' as an average across all sessions. Not all staff completed an evaluation form for reasons such as having to leave the session early. Table 4 shows the results for this, and provides a breakdown of this rating according to team / sector.

Table 4: *How trainees rated the training session overall*

Team / sector	Number completing post session evaluation form	Percentage of trainees rating the training session as 'excellent' or 'good'
GPs	9	89% (n=8)
PNs	6	100% (n=6)
CCT & OPMH	22	100% (n=22)
Social care	43	90% (n=39)
Care home	40	94% (n=38)
Pharmacy	3	100% (n=3)
Voluntary sector	29	90% (n=26)
Total	152	95%

Trainees were also asked trainees to state what they liked most about the session, what aspects could be improved and what impact the training would have on their work or role. The top three things most liked about the session (as an average across all sessions and sectors) were:

1. How interactive the session was
2. Learning / refreshing knowledge of 'MUST'
3. The tools and information given

The top three impacts of training on their work or role were:

1. Increased knowledge and awareness,
2. Confidence using 'MUST' and applying it in the workplace
3. Feeling able to improve care and engaging more with patients in their care

Results from online surveys 2-5 months after training

Online surveys were distributed to 88 people (8 GPs, 22 Nurses, 35 Social Care staff and 23 Voluntary sector workers) 2-5 months following the training sessions. In total, 20 surveys were completed (2 GPs, 7 Nurses, 10 Social Care staff and 1 Voluntary Sector worker). This represents an average response rate of 23% (ranging from 4% in the voluntary sector to 32% of nurses) and, therefore, findings cannot be assumed to be representative of all trainees.

Knowledge and confidence since training

Survey results indicated that training succeeded in raising awareness across 79% (n=15) of survey respondents. Most respondents reported feeling more confident in their knowledge of malnutrition, and felt their practice had changed as a result of training. Despite this, reported confidence in using 'MUST' varied; most nurses were confident with using the tool, whereas only 4 out of 10 social care workers felt confident. Routine use of 'MUST' in practice was low, as shown in table 5.

Table 5: *Malnutrition practice since training*

	GP (n=2)	Nurse (n=7)	Social Care (n=10)
More confident to begin a conversation about malnutrition	1	3	7
Raised awareness about malnutrition and what to do/who to refer to	2	6	7
Increased confidence to use 'MUST'	*	5	4
Using 'MUST' with people I feel are at risk	*	2	1
Using 'MUST' with every person I see	*	3	1
Increased knowledge of 'MUST'	2	**	**
Increased knowledge of Oral Nutrition Supplements & local formulary	1	**	**
My practice has not changed	0	0	2

*question only for nurses and Social Care, **question only for GPs

Screening and use of nutritional care pathways

Over half the respondents (n=10, 53%) had completed 'MUST' with or without using the Care Pathway, although there were still six respondents seeing service users who fitted criteria and were not using 'MUST' or the Care Pathways. Both GPs felt the care pathway was very easy to use, however, only one of the GPs had used the care pathway with a person over 65. This was in comparison with the social care sector, who commented that "'MUST' and the nutrition care pathways could be easier to use". Questions about confidence using the care pathways revealed that whilst two of the respondents felt very confident using them, the majority were neutral (n=6, 60%) and two people did not feel confident. Nurses generally felt confident with 'MUST' use but when it comes to using the care pathways, the confidence rating decreases.

Use of malnutrition training & associated impact on service

A total of 14 people provided examples of how they have used the malnutrition training and the associated impact on the service users (see table 6). The voluntary sector respondent and five others did not provide a response to this question. Two respondents reported they had not seen anyone in the pilot area. Examples of use of training made reference to provision of dietary advice, knowing

who to involve and recognition of weight loss. There were limited comments made by respondents on the associated impact on the service (with the exception of a social care respondent).

Table 6: *Comments on use of malnutrition training and associated impact on service*

Responses to question (1 GP, 5 Nurses, 8 Social care* respondents)	
GP	• Provided patient with Food First Leaflet as first line approach in improving their nutrition
Nurse	• Identified malnutrition and able to more confidently advise and on establishing further need know how to refer on • Identified nutritional needs and able to identify improvements using 'MUST' • Am able to give better advice for fortification • We spoke about nutrition after the patient had been discharged from hospital • More appropriate dietary advice
Social Care*	• Provided advice on high calorie snacks to boost intake • Have used information to have discussion about increasing calorie intake • Able to identify a client in a care home with 'MUST' of 3 who had lost considerable weight over past 3 months and had a BMI of 16-17 (home was weighing him and GP had prescribed supplements, but he had not at that point translated to a holistic nutritional plan for malnutrition). As a result, food fortification was discussed, a referral to the community care team made, and the nutrition plan updated following discussion with the patient, e.g. puree his foods separately and use moulds to shape food and spices to flavour it. This has led to better nutritional planning and training needs of the care home were identified • More aware of weight changes and ask questions related to this • Discussion with people about healthy diets and ensuring weight isn't lost • Opened up a discussion about weight loss and client not eating

* two social care respondents entered n/a

Further training needs

Three respondents (1 GP, 1 Nurse and 1 social care staff) reported having further training needs. These focused on information on the prescription of oral nutritional supplements, calculating percentage weight loss and information recording.

Voluntary sector response to additional questions

The one voluntary sector respondent reported that training had met expectations and commented that it was "very good information". Their nutrition knowledge had improved and "they now knew who to refer people to if they are at risk." Their take home goal was "to be able to be sure of identifying malnutrition and if suspected who to talk to about it." They had not yet implemented any of the information from training, however they reported to have "future plans for if the need arises and they will certainly be using the information they were given." The respondent also reported they had no further malnutrition training questions and reported there was no one else in the team that could attend training.

Chapter 4:
Evaluation of training follow up & support: health, social care & voluntary sector

Methods

Following training sessions, teams were offered support and follow up appropriate to their teams and team structure. This included a mixture of attendance at team meetings, shadowing to support and quality assure screening and one-to-one meetings. It was originally planned to offer and provide support 4-6 weeks following training.

The purpose of this follow up was to:

a) Obtain feedback on how the OPEN project was progressing, and
b) Support teams in identifying people at risk of malnutrition and using the nutritional care pathway appropriately. It was planned that teams would initially be followed up 4-6 weeks post training

Results

Results of the numbers and types of support sessions are presented in table 5. It proved challenging to deliver follow up at 4-6 weeks due to a number of reasons, including staffing issues, communication issues and the number of training sessions delivered at different times. A summary of the successes and challenges highlighted from the support and follow up offered to teams is provided in the team subtitles following table 7.

Table 7: *Follow up support and sessions offered / run after the training sessions (months all refer to the year 2015 unless specified otherwise)*

Team / sector	Team meetings attended	Other contact with teams	Shadowing opportunities ☐	Details of student project (if applicable)*
GPs and Practice nurses (PN)	1 Integrated Care Team (ICT) meeting (St Andrews Surgery); 1 team meeting at Boyatt Wood surgery	Follow up phone calls to Parkside GPs and PNs between June & August. Ad hoc support offered to individual staff and practices	Not offered	Parkside & St Andrews - project to compare malnutrition screening using 'MUST' vs GPs use of clinical judgement
CCT	Dietitian attended weekly 'virtual ward' for 1 month post-training. Attended 1 team meeting in June	Email & phone contact with team leads	Dietitian observed a staff member carrying out two patient screenings in August	n/a
OPMH	Attended 1 team meeting in June	Email & phone contact with team leads	Dietitian observed a staff member carrying out one patient screening in May	n/a
Social care – social workers	2 follow up meetings	Email contact with all attendees. Support in creation of new, simpler data collection forms	Offered but not taken up by team	n/a

Social care – OT	Attended 2 team meetings in May & July		Offered but not taken up by team	n/a
Social care - CIT	Support meetings offered but not taken up by team		Offered but not taken up by team	
Community pharmacy	n/a	Dietitian visited Pharmacist monthly post training for 5 months. Counter staff visited weekly then fortnightly for 3 months after training to monitor progress with tally chart	n/a – as not screening using 'MUST'	n/a
Care home	No	Yes	Full day / month after first 3 training sessions (6 x 1 hour sessions with the dietitian & 2 staff members per day; involved 3 'MUST' screening cases for the staff members to work through and receive support for). 2 staff were then shadowed in Feb 2016	n/a
Voluntary sector	n/a	Meeting with CEO in March to discuss resource needs and create new resource	n/a – as not screening using 'MUST'	MSc Public Health Nutrition student evaluated the voluntary sector training impact

* an abstract for the student project to compare malnutrition screening using 'MUST' vs GPs use of clinical judgement (appendix 1), and a summary of the student MSc project to evaluate the voluntary sector training impact (appendix 2) can be found in the appendices

GPs and Practice Nurses

- The project dietitian attended an Integrated Care Team meeting, but neither nutrition or the use of the nutritional care pathways were raised at the meeting
- Two staff members completed the online survey (results shown at the end of this section)
- Follow-up phone conversations held with GPs and PNs revealed that despite lack of use of the care pathways, staff felt armed with the knowledge that they had a care pathway in place which could be used to identify and treat patients at risk of malnutrition in the future
- Conversations with both GPs and a PN revealed that they felt that resources were needed for this project to work, e.g. a commissioned Dietitian, time, funding or GP incentive. This may have accounted for the lack of screening data carried out by the practice
- One practice merged with another practice mid-way through the project, which was another reason why the project work was not a priority for this practice

Community Care Team (CCT)

- The CCT had completed a large number of 'MUST' screenings, which is partly due to their organisational policy requiring them to screen all patients monthly
- One month post-training they changed their existing 'MUST' recording forms to the OPEN data collection forms and began providing data for OPEN in addition to their standard practice (it was commented that the OPEN forms were the easiest ones they had). An option of collecting the data electronically using Rio was investigated but would have required development of the system for this to happen

- Project dietitian attendance at the 'virtual ward' was useful - although nutrition issues were not always discussed, it was a good way to get to know team members and offer support, regardless of whether the support was required
- Project dietitian attendance at the team meeting in June highlighted that due to time issues, the team would prefer to give future feedback through an online survey rather than face-to-face
- Results from the online survey disseminated 2-5 months following training revealed that the majority of community nurses felt there was adequate support from the project team on the use of the nutritional care pathways. However two respondents wanted more support; this may be reflective of the nurse awaiting follow-up training and the nurse who reported that they "just need to carry a copy of the care pathway"
- Shadowing / observations were challenging to coordinate time-wise, as there needed to be a staff member carrying out 'MUST' screening when the project dietitian was able observe. Despite this, the support was found to be beneficial for answering 'MUST' calculation questions and determining the level of use of the nutritional care pathways

Older People's Mental Health team (OPMH)

- Shadowing / observations highlighted the length of time it was taking staff to undertake a thorough 'MUST' screening and giving advice for those who had recently learnt the calculations and use of the care pathways (this team were not screening prior to the project)
- Attendance at the team meeting in June highlighted a lack of data collection sheets (screenings), which was reportedly due to a limited amount of time in an appointment

Social care

- Only two staff attended the first follow up session in May 2015 – this was due to staff reporting to not being seeing people fitting the project criteria, lack of 'MUST' screening (as staff felt this was outside their role) and other work commitments
- Following the second team meeting in June 2015, due to the feedback received, the 'MUST' recording forms were amended to make them simpler. It was hoped this would increase screening and care planning
- Due to changes in team lead and several redundancies, other clinical issues appeared to take priority, and despite many offers of support, screening occurred sporadically after this
- Results from the online survey disseminated 2-5 months following training revealed that although the social care respondents were not tending to use the nutrition care pathways, all respondents felt the support from the project team was adequate and there was a comment that "we help each other if we forget how to do it"

Care home

- Shadowing / observations were useful and highlighted members of staff who still needed more support, and those who were competently able to complete 'MUST' and nutritional care planning, which was fed back to managerial staff for further in-house support purposes
- The main challenge was obtaining dates for further support sessions and initial training for untrained staff

Pharmacy

- Visits with staff post-training revealed that the tally chart was not being used – staff reported having limited conversations with patients about nutrition

- Both counter staff work part-time and so does the Pharmacist, which has been hard to gain feedback from all three staff and provide the continuity of resource. They have also employed locum Pharmacists and are awaiting employment of a full-time Pharmacist
- The Pharmacist reported they would have a new full-time Pharmacist beginning at the end of September, which would provide the resource and continuity for the OPEN work. The new Pharmacist turned down the contract, so the Pharmacist post is still currently vacant

Voluntary sector

- At a meeting with the CEO of One community, the need for a new resource around starting a conversation was discussed (as well as including some information around conversations in the training sessions). As a result, a new resource entitled 'four steps to a conversation about malnutrition' was put together, and this was included in the session plan from October 2015
- Emails were sent to all attendees, but no other feedback was received (other than 1 volunteer completing the online survey). It was noted that upon trying to contact staff by email, several emails bounced back stating that staff had moved on from their previous job role, suggesting a high turnover

Chapter 5:
Evaluation of awareness sessions and events for the general public

A series of awareness sessions and events were put together to increase the general public's (and voluntary sector in some instances) awareness around undernutrition. These sessions / events happened in a variety of locations and formats, including stalls, meetings and talks. A summary of each event / talk is provided below, along with an evaluation of what went well, and how the event could be improved, where relevant. In addition to the launch tea party which provided awareness to approximately 30 people (mixture of members of the public, voluntary sector and healthcare workers), a total of 14 sessions and events provided malnutrition awareness to 200 members of the generic public and 26 voluntary sector staff. These figures are independent to the formal training figures included in table 1 of this report.

- ***Eastleigh launch tea party (March 2015)***

Voluntary workers, older people and their carers, and health and social care workers from Eastleigh Town Centre were invited to a tea party at Well's Place, to celebrate the launch of the OPEN Eastleigh pilot. The aim of the tea party was to raise awareness about malnutrition in older people, and what can be done to reduce it, and to share information about the work in Eastleigh. Approximately 30 people attended this event.

- ***Carers Action Network Talk (March 2015)***

The dietitian gave a short talk to raise awareness of malnutrition to 8 voluntary sector works from the Carers Action Network, a group which challenges health, social and educational services to ensure that the Carers Act (2004) is implemented and that carers' views are made known.

- ***Eastleigh library stall (June 2015)***

A dietitian manned a stand at the local library for three hours, with the aim of raising awareness of malnutrition and showcase the project in Eastleigh. A flyer had been put together and provided to the library beforehand to generate interest. A Monday was chosen as the library suggested this day would have the greatest footfall. The dietitian talked to 6 people, all of whom had different ideas about what the poster entitled "are you eating and drinking enough?" related to. Some related it to eating disorders and others to obesity, so although only limited numbers engaged with the stand, it did succeed in raising awareness of malnutrition. Being clearer about the topic of 'undernutrition', as well as including some activities or games aimed at children is needed to help entice people to engage with the stand more

- ***Eastleigh market stall – June 2015***

Two dietitians held a stand for the whole day at the local weekly market as part of International Dietitian's Week. Conversations were held with around 20 people (several of which were regular market stall holders), and despite not being the target audience of older people, good discussions around malnutrition and healthy eating were held. The dietitians asked people what came to mind when they thought of the word 'malnutrition'. The most common answers were low budget and being underweight. Other themes included 'medical issues', 'loose clothing', difficulty cooking', 'no energy', 'not buying the right food', 'weight loss', 'Ethiopia', 'loneliness', 'no support', 'no appetite' and 'low motivation'. Several things could have helped make the stall more of a success; a) Include a

game with a small prize to entice people in, b) Include a poster board and make a sign specifically for malnutrition because without actually approaching the stall people still just saw the posters and were a little misled by what they we were promoting, and c) Man the stall during the busiest times (10am – 2pm) rather than all day

- ***Relatives meeting, Fleming House (June 2015)***

The dietitian attended the relative's meeting and had a short slot on the agenda to highlight the work of the OPEN project to residents' relatives. There were 4 relatives present at the meeting

- ***Velmore community centre clinic (June 2015)***

The dietitian attended the clinic waiting room and talked to 4 people to raise awareness of malnutrition and highlight the work of the OPEN project

- ***Age Concern AGM***

The dietitian attended Age Concern's AGM and had a short slot on the agenda to highlight the work of the OPEN project to the 24 people present at the meeting

- ***Eastleigh Mela (July 2015)***

A dietitian and four public health students attended the Eastleigh Mela, which was an all-day event organised by the local Asian Community. Other stalls present at the event included One Community, Eastleigh Borough Council and the Asian Elder's Group. The team were set up and ready by 10am, with a few activities available for attendees at the event, including guess the calories (aimed at determining what foods have the most calories in order to fortify these for malnourished elderly), writing on post it notes what attendees thought of when they thought about malnutrition and any general discussions about anyone they know with malnutrition. The team talked to approximately 62 people over the day and noted as many of the themes of these discussions down, as possible. Common themes were signs of being underweight, having an underlying illness and the social aspects of eating. Many of the people who approached the stall had some sort of experience with malnutrition; not necessarily suffering themselves but recognised malnutrition in various family members and friends. The dietitian and students together worked well and there were enough people to manage the event. The students were a great asset to the day. Having familiar people and organisations with stalls nearby was really helpful in terms of being able to support other stalls like One Community by directing people to and from each other's stalls. Several things could have helped make the stall even more of a success; a) Including cultural foods in activities, b) Rearranging the poster so that people knew the theme for the stall before they approach it and put more of a malnutrition focus on the whole stall, and c) Providing flyers to associated stalls to hand to attendees to show where we are or to attend malnutrition volunteer training

- ***Older People's Network Forums (June, July and October 2015)***

Three forums were attended in different locations, including Velmore and Fair Oak. The agenda of each forum consisted of two hours of short presentations interspersed with networking time. The dietitian gave a short presentation and case study to the group, and provided copies of OPEN resources and posters. Good networking opportunities were available with services including the Dementia Advice Service and Hampshire fire service. 18 people were present across these forums

- ***Asian elders groups – March and October 2015 (26 at each)***

A dietitian provided two training sessions to the Asian elders group in Eastleigh. The first session was similar in content to the sessions delivered to the voluntary sector – highlighting the causes and consequences of malnutrition, signs of malnutrition and dietary support (food first). Evaluation of

the session revealed that many of the group did not really connect with the content and find it useful. A second session was then delivered, which focused more on healthy eating and 'eating well', and then covered malnutrition advice for people not eating well. 26 people were present at each session

- ***November 2015 – lunch club at Well's Place***

The dietitian attended the lunch club to talk to older people about malnutrition and highlight the work of the OPEN project. 18 people were present at the lunch club

- ***November 2015 – Friendship club at Velmore Centre***

The dietitian attended the club to talk to older people about malnutrition and highlight the work of the OPEN project. 10 people were present at the club

Conclusions

How the project has changed practice

The use of pre- and post- project implementation surveys was invaluable in discovering how to tackle the challenges of developing an integrated project with many different teams and sectors involved, and to plan the intervention particularly with reference to the priorities of the staff group, the training topics required, and resource development needs.

Those teams/sectors that completed both pre and post implementation surveys have shown positive changes in practice. Several teams appear to screen elderly patients for malnutrition more regularly and be following care pathways, and there is improved awareness-raising of the issues of malnutrition in the community. Whilst post-implementation surveys were only completed by four of the teams / sectors, many of the changes and impacts of the project have been captured as a result of post-training support and follow up, and also reflected in the screening data (e.g. frequency of screening, different staff initials completing screening etc).

Whilst not necessarily coming from the data (but more from discussions at meetings with key staff as a result of the project), the project has highlighted gaps in practice, leading to improved nutrition practice (e.g. the organisation Southern Health who employs the CCT and OPMH are looking at ways to improve their nutrition policy and training opportunities) and increased activity around nutrition, although not necessarily full involving full screening (e.g. looking at ways to involve voluntary sector organisations with basic screening questions). Whilst it's evident that practice has been changed as a result of the training and support provided, it has not happened in the way needed to actually measure change.

Development of training packages and resources

The project was successful in piloting, reviewing and finally publishing (on the Wessex AHSN website) training packages for seven key teams / sectors, and generic nutritional care pathways that other areas can use and localise. In addition, awareness resources (malnutrition awareness leaflet and suite of three posters) have been professionally produced, which have been fully piloted and reviewed by a wide variety of local teams and healthcare professionals. All these resources have been endorsed by the British Dietetic Association (endorsement period of three years from June 2016).

Training

The training sessions were successful in improving awareness and practice in malnutrition, as well as confidence in using 'MUST', appropriate signposting and provision of basic dietary advice. Training was well received and positively evaluated across all teams and sectors. Some sessions went better than others (in terms of knowledge change which was assessed by analyzing the difference between the pre- and post-session quiz) which appeared dependent on a) whether their current practice related to the work b) what their background malnutrition knowledge was and c) what extra work was being expected of them.

Training follow up

Despite offering a wide variety of follow up support, it proved challenging getting uptake on this support from teams. There are a variety of reasons for this, including staff shortages, major changes in management, and other clinical pressures on their time.

Findings from the follow up surveys indicated that a most respondents had not seen a service user in the pilot area and there were still areas of low confidence for 'MUST' and care pathway use. It is important to note that while these surveys were done in July and August 2015, the project involved data collection until April 2016, and a follow-up survey was not done to check if this had changed as the project progressed. Despite the lack of confidence using 'MUST' the respondents did not identify are further training needs that could not be met by the project team, and obtaining further follow up with teams proved challenging.

Awareness and events for the general public

Provision of awareness events for the general public were an important part of the project in Eastleigh. However, preparation and attendance was fairly labour-intensive, and limited evaluation data was obtained due to the nature of the events.

Recommendations

The following recommendations have been put together regarding how things could be improved in similar projects in the future:

- Initial attendance at team meetings (with each team) to outline the project details and expectations from the outset, including diary dates for training sessions and follow up / support sessions agreed in advance
- Engagement in the whole project is key from the outset; consideration into setting out a formal agreement between the health and social care teams and the project team
- Screening practice and opportunities for follow up with the GP practices may have been improved by involving the Practice Manager
- Selection of a 'nutrition champion' for each team agreed at the project outset
- Future projects should involve pre and post implementation surveys / discussions as these provided valuable insight into how practice had changed and the issues important to each team
- Due to the diverse group of people trained in the voluntary sector training sessions, and high turnover of staff, it was difficult to obtain follow up for this group. Determining and agreeing on an appropriate method for following up and contacting people at the training session itself may be helped alleviate this (e.g. recording personal email addresses rather than 'work' ones)
- Development of a tool or template for obtaining case study information may be a useful way of capturing follow up data for the voluntary sector
- Future projects can use the training plans, nutritional care pathways (generic versions which can be localised) and awareness materials developed as part of this project. Involving a multi-disciplinary team of staff in developing and evaluating the materials was important in ensuring the toolkit is fit for practice

- Obtaining some baselining data around the level of screening and care planning carried out by the relevant teams prior to the project would help to indicate whether the project was successful at increasing the frequent and quality of screening and care planning
- Whilst the nutritional care pathways were covered briefly as part of the training session (including the use of case studies to consolidate knowledge), feedback from the online survey and staff and team meetings revealed that staff still lacked confidence in using them. Whilst it would not be possible to fit extra activities into the current session plan, if time allowed in future sessions, it would be recommended that a longer time was spent training on use of the care pathways following 'MUST' screening.

Appendices

Appendix 1 – abstract of student project

Is 'MUST' more effective than clinical judgement in establishing the prevalence of malnutrition in those aged 65 and over in the GP setting?

Background
'MUST' (Malnutrition Universal Screening Tool) is the tool that has been recommended for use by NICE (2006) for health professionals within the community to screen for malnutrition. Malnutrition can be defined as the lack of proper nutrition caused by failure to consume a sufficient amount of food. Over 1 million people aged 65 and over across the UK, are either malnourished or at risk of malnutrition. It has been recommended that older adults should be screened for malnutrition to enable the early identification of those who may be malnourished or at risk. Early identification of malnutrition can lead to shorter hospital admissions, longer health related quality of life and a better immune system. Compliance to this recommendation has been an issue with GPs and PNs claiming that they are able to identify malnutrition without using the recommended tool based on their clinical judgement. This study aims to answer the question - is MUST more effective than using clinical judgement in establishing the prevalence of malnutrition in those aged 65 and over in the GP setting?

Aim
To be able to compare the rate of prevalence identified by MUST compared to the rate identified by clinical judgement to determine which method was more effective.

Methods
Mixed methods were used in the form of a semi structured interview; interviews were conducted on four GPs and three PNs. The transcripts were transcribed and thematically analysed and coded which lead to themes being generated and used as results. A comparison test of best fit (chi- square) was then done from results obtained by the researcher and results obtained by the GPs and PNs. Participants were recruited from two surgeries in Eastleigh by the researcher. An exclusion and inclusion criteria was used to select fitting participants.

Key findings
It was found that GPs and PNs were aware of malnutrition, and were aware that malnutrition screening was useful, however the interviewed health practitioners found a lack of time, too many staff responsibilities and difficulty identifying at risk patients to be barriers that hindered them from implementing screening. It was also found that MUST was able to identify more cases of malnutrition in comparison to clinical judgement, however due to the small size of the study and the duration of it, it was acknowledged that the results could not be generalized.

Conclusion
In conclusion MUST was able to establish a greater prevalence of malnutrition than the clinical judgement of GPs and PNs comparatively, and clinical judgement was able to accurately identify some cases. Malnutrition should be every ones responsibility especially those who come in to regularly contact with those aged 65 and over, this will enable early identification and reduce existing prevalence.

Appendix 2 – Summary report of MSc student project to evaluate the impact of voluntary sector training

Implementation of the OPEN Project in the Voluntary Sector in Eastleigh, Hampshire: A Service Evaluation

Aim and Objectives
In February 2016, after five OPEN training sessions had been delivered, a service evaluation was undertaken with attendees at OPEN training. The evaluation focused on one OPEN project process measure: to obtain opinions about the delivery of the training sessions, and two indicators of impact: 1) awareness of the OPEN project and of malnutrition among older people who had attended voluntary sector activities in Eastleigh; and 2) perceptions of community workers' confidence (about) their ability to raise awareness of malnutrition among elders in the community.

Methods
A cross-sectional design used mixed qualitative methods that enabled participants to speak freely and provide insights into their opinions. Semi-structured interviews (SSI): Key opinion leaders responsible for voluntary or public sector community services for the elderly were eligible for semi-structured interviews (SSIs). The eligible individuals were partners or stakeholders or worked in organisations or businesses that served the project's target area in Eastleigh *and* had attended an OPEN training session. They were recruited by email with a Participants Information Sheet (PIS) through OPEN, with at least three reminders. 1Community management nudged some participants.

Focus Group Discussions (FGD) were chosen for lay elders (65+) who had attended a group coordinated by one of the OPEN trainees, had received OPEN training from a trainee (i.e. eligible for a SSI) or training offered by OPEN. Group leaders and others who contacted elders were unsuccessful but one group chair invited members who spoke English fluently. All individuals taking part in the evaluation completed and signed a consent form. They were assured of the right to refuse to answer questions or withdraw at any time and to anonymity and confidentiality. The study obtained suitable approval from a Southampton University Ethics Committee (ERGO).

The interview schedule and topic guide were designed to cover the objectives of the service evaluation and enable participants to express their own views. Interviews took place at 1Community offices, Eastleigh Borough Council and Wessex AHSN offices.

All the interviews and group discussion were transcribed in full. A thematic approach was used to analyse the transcripts. Coding, in duplicate for quality assurance distinguished evaluation (normative) themes from emergent (formative) themes. Brief quotes used in the report reflect opinions voiced by many or otherwise reflect a consensus in the FGD, while preserving confidentially and anonymity. Attention was paid to the duration of responses and the language or feelings expresses, nonverbal communication such as silence or gestures that indicated issues salient to interviewees and FGD participants.

Findings
Interviews: The six community and / or voluntary sector workers interviewed comprised 5 females and 1 male, 20% of the 30 eligible; half the intended number, due to lack of time and difficulty of recruiting participants. It is possible that having an incentive, such as a raffle or lucky dip or gift

vouchers could have increased recruitment, but there were no resources to do this. It was neither ethical nor practical to send more invitation emails or to use telephone recruitment.

All the interviewees were senior staff managing or leading services who reflected the range of business or organisations that had sent staff to OPEN training sessions in 2015. Their job roles did not entail working directly with elders.

All the interviewees said that they had learnt from the OPEN training. For all but one this was entirely new information, because prior learning entailed other aspects of nutrition (healthy eating/ living) or care of the elderly. They spoke speak in detail about a range of information that they had gained from OPEN training. The main lessons learned included: what the signs of malnutrition are (4/6), how high malnutrition rates are (3/6), that good nutrition is a means of reversing malnutrition (2/6); that weight loss is not a feature of normal aging (2/6). One interviewee mentioned each of the following: that they had learnt how to carry out a conversation with the elderly about or to raise malnutrition awareness or the nutritive values: food as a positive not a means of losing weight: and finally, the high cost of malnutrition to the NHS. One interviewee reported that the OPEN training reinforced prior learning and added information.

Four interviewees said they had used the training with colleagues e.g. to train staff i.e. build capacity. Two had applied their knowledge with their families. Three planned to use the training either in new job roles or in new or extended services within their organisations and would like OPEN to be extended to other organisations.

Interviewees spoke in some detail about the difficulties they found in trying to raise malnutrition awareness 'because it is just difficult' and inherently complex because it 'needs to be addressed in conjunction with other problems, not in isolation'. Barriers to change mentioned included underlying 'health conditions that that may cause intolerance to or deprive (elders of) certain foods' or 'learning difficulties' (or) 'Alzheimer's may affect feeding as well other aspects of health'. Other causes of the difficulty of communication about malnutrition that 3 interviewees mentioned were: people being nervous; finding it difficult to initiate such conversations for fear of intimidating the client, because the term malnutrition 'puts people off'. Other barriers identified were cultural norms such as respect for the elders; human attributes such as having fixed routines and being set in one's ways. One provided an insight into the community voluntary services situation: volunteers are under pressure due to the 'volume of (their) work' that makes it hard for them *'*to remember finer details of all issues they deal with'. Sometimes volunteers are 'unsure where to signpost clients'.

Focus Group Discussion (FGD): Five elderly Asians from an existing social group participated in the FGD. One interviewee also attended the FGD. By contrast with the interviewees, the elders in the FGD were uncomfortable about and avoided of the subject of malnutrition, as shown by what was said and left unsaid in the FGD. The OPEN training was described as *"…a presentation for old people… this really isn't for us…"*. Therefore the community group had asked OPEN for another session on their own choice of topic (Healthy Eating). When asked a direct question about malnutrition awareness one participant spoke movingly from personal experience of an elderly relative who had "dwindled after bereavement" but silence prevailed.

Participants in the FGD spoke at length about what they did to promote their own health and well-being by being physically active, including walking with a spouse, or in a 'health group', or with a dog, doing sitting exercises, riding a bike and also going curling. They animatedly shared ideas about

modifying their recipes and cooking methods to reduce the amount of fat or oil in cooking without sacrificing flavour; how to vary their food choices, including avoiding take-ways that they perceived to be the least healthy options. In all that was said they clearly reflected their learning about healthy eating from OPEN or prior training by other organisations such as British Heart Foundation or a 'Cook and Eat' session some years before, as well as what their children brought home. They were strongly committed to and understood prevailing healthy living messages for the population as a whole.

FGD participants said that they were satisfied with the quality of the OPEN presentation. However, in relation to the OPEN materials they had received, they said that the print (font) size was too small. They also wanted future training to be tailored more to the preferences and needs of their Asian audiences: such as, for those who speak little or no English, having an interpreter able to speak Urdu, Hindi or Gujarati; for the benefit of all Asians, using culturally appropriate examples, either in the form of illustrations in the leaflets or samples of foods from Asian cuisines during the training.

Discussion

This service evaluation explored the opinions of senior community and voluntary sector service workers about their abilities to engage in conversation with and communicate about malnutrition. A qualitative study could not verify abilities or measure impact on nutritional status. It was too soon after the project had started to be able to gauge whether it was at a scale commensurate with affecting such outcomes as reducing inequalities in nutritional status of elderly people in Eastleigh. The study followed OPEN's own community development approach, inclusive of workers from areas neighbouring its geographical target area. This indicates the *influence* the OPEN project has on its wider community of practice. Because the interviewees were not asked where they worked, it was not possible to assess OPEN's influence in its target area. The service evaluation enabled an interim assessment of one indicator of impact and the findings may help to inform the planning of further impact evaluations in due course.

The evaluation found that the OPEN Project had itself reached one population group and would have an indirect effect on other elderly through trained community and voluntary service workers, who would in turn reach older adults in Eastleigh through their staff and /or services.

Overall, the variety and scope of responses given by the participants indicated that all were familiar with the OPEN Project and the training it had provided. In both interviews and the focus group discussion several, rich and detailed and largely positive opinions about the delivery of the training session were obtained. The evaluation showed that OPEN training in general had been accepted, understood and appreciated by all, as the interviewees and FGD participants had favourable opinions about the usefulness of the contents of OPEN training. The topics that found favour differed: That malnutrition awareness was high among interviewees indicates successful fulfilment of the OPEN project's remit. Interviewees' awareness of malnutrition was attributable to OPEN training; it had increased knowledge, provided motivation and stimulated intention to apply or use what they had learnt in their work. The interviewees intimate understanding of the issues concerning the elderly was evident in the extent of their responses and the fact that they held "in depth conversations" with colleagues in their offices and gave advice to carers/volunteers in ways that augur well for service enhancement in the short term. This is a very important positive finding, because, albeit that the sample of interviewees was smaller than intended, they reflected the range of business or organisations within or collaborating with the community voluntary service sector, at the level of seniority and influence at which OPEN had aimed.

There is evidence that OPEN training has contributed to building capacity to raise awareness of malnutrition, how to prevent it and signpost to preventative and treatment services. This valued as complementary to and supportive of the work of other services and projects to promote health.

For the community group malnutrition awareness was still a difficult topic but the bespoke replacement training on healthy eating provided in response to the community's felt needs was very well received.

Interviewees' and the FGD participants' views seem to reflect the different perspectives of professionals and lay people, respectively. The difficulty professionals find in raising malnutrition awareness with lay service users was born out by sensitivity to the point of avoidance perhaps aversion to the subject in the FGD. This was the key difference in reception of OPEN's central message about malnutrition awareness was that in general interviewees had embraced OPEN training, valuing it for adding to their prior learning, and articulating clearly how OPEN training added value to their work and could also benefit the work of others. By contrast, lay elders in the FGD eschewed the malnutrition message, instead asking for and evidently relishing training around a more positive keeping healthy message. However this interpretation needs caution because the FGD participants were from a very small ethnic minority within the Borough, so they may not reflect the views of the all Asian elders or elders from the ethnic majority or from other ethnic minorities. While the presentations had been well received in general there was practical feedback of the kind that is likely to reinforce evaluations after individual OPEN training sessions: older adults whose visual acuity is failing request larger writing on the leaflets: a point likely to benefit elders generally. Similarly, a request for illustrations in talks relevant to specific audiences is good practice for OPEN (or any partners) training lay audiences. However, the expressed felt need for translators is likely to be impracticable amid current financial constraints and at a time when everyone living in the country is expected to be able to speak English. Beyond a sympathetic hearing, alternate remedies that could be sought include encouraging community self-action.

Conclusion

The OPEN project training is valued by trainees and is raising malnutrition awareness. OPEN could consider tailoring messages to different audiences while retaining its core function and purpose. Health promotion and primary prevention among lay elders could be achieved by emphasising 'staying well' or 'keeping healthy' through eating for health. OPEN could reserve for training middle and senior level community, social (and health) workers for them to cascade to the frontline workers or volunteers, the technical and ethically, morally complex, indeed unpalatable aspects of malnutrition awareness points (the size and nature of the malnutrition problem, its detection, remedies and sources of help, and approaches to solutions, etc.).

Version Control

Date	Version	Name	Comment
04Aug16	0.1	Annemarie Aburrow	First Draft
18Aug16	0.2	Annemarie Aburrow	Second Draft with Kathy Wallis & Jane Murphy feedback
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