"Nutrition in Practice": Nutritional Screening by One Community volunteers in a GP Practice in Eastleigh, Hampshire

1.0 Executive Summary

A six-month pilot project was run by the Wessex AHSN in conjunction with One Community (third sector organisation in Eastleigh) and St Andrews Practice in Eastleigh to evaluate the potential and effectiveness of a volunteer carrying out nutritional (undernutrition) screening in a GP Practice.

Training was provided by a dietitian to the volunteer to provide them with the appropriate knowledge and skills to carry out the project (a total of four volunteers were trained as part of the project, although one decided not to take part). Training was also provided by One-Community to ensure the volunteer(s) had the appropriate knowledge of local services available for signposting to.

Once trained, the volunteer(s) spent one morning a week at the GP practice, where they aimed to see all patients over 65 years of age who were visiting the practice on that morning. They carried out nutritional screening using the Malnutrition Universal Screening Tool (MUST)[1] and provided advice and signposting around nutrition and wellbeing as appropriate and as guided by the pathway (see appendix 1). All patients with a medium/high MUST category were supposed to be invited back for a review to re-screen and monitor their progress. The data collection form was used as part of the project (see appendix 2).

Key results of the project:

- 121 older people were screened
- 7 people were found to be at medium or high risk of malnutrition
- Prevalence of malnutrition was 6%
- 9 people were followed up (screened more than once)
- 3 of the people at medium risk (MUST=1), were followed up in a month and their risk had improved from medium to low. The remaining people either declined follow up (n=2) or no follow up was planned for an unknown reason (n=2)
- The OPEN undernutrition leaflets[2] were given out to seven people (3 of whom were at medium or high risk of malnutrition)
- Verbal or printed information on a variety of One Community services (e.g. lunch clubs and transport services) was provided to 29 people (most of whom (n=28, 97%) were at low risk of malnutrition)

Feedback from the volunteers and GP practice staff helped identify the value of the project, and improvements which could be made if a similar project was run in another GP practice. Cost avoidance figures were calculated for the three people who had a reduced risk of malnutrition, as determined through follow up as £4101.12 (taking account of the cost for screening).

Using data from Hampshire Health Record (2013-14) on the total number of older people registered at St Andrews surgery, assuming that 5% of this population are at increased risk of malnutrition, and 80% of them were screened using MUST with 50% of them reducing their MUST score, a cost avoidance of £42,021 would be achieved. This project demonstrates the potential significant cost saving that could be made if the project was continued or rolling out wider.

[1] http://www.bapen.org.uk/pdfs/must/must_full.pdf
[2] https://www.slideshare.net/WessexAHSN/open-flyer-eating-well-feeling-good

2.0 Project Background & Introduction

2.1 Context

Key documentation and guidance around malnutrition suggests the potential role of the third sector in signposting and supporting people at risk of malnutrition. Whilst Luger et al (2016)[3] concluded that home visit programmes by volunteers had the potential to promote good health and allay social isolation, limited published evidence is currently available to support the role of volunteers in identifying and supporting older people at risk of malnutrition. A project was run by the Wessex AHSN in conjunction with One Community and St Andrew's GP Practice in Eastleigh to evaluate the potential and effectiveness of a volunteer carrying out undernutrition screening in a GP Practice. Both One Community and St Andrew's Practice took part in the OPEN Eastleigh[4] project during 2014-2016, so relationships were already established between organisations.

2.2 Aims

- To evaluate the potential and effectiveness of a volunteer carrying out nutritional screening in a GP practice, and the extent to which the pathway (including advice, signposting and follow up) is followed
- To determine undernutrition prevalence amongst patients over 65 years attending their GP practice

2.3 Objectives

- To screen all patients ≥ 65 attending the practice one morning a week; it was anticipated that between 130 and 260 patients will be screened over the six month project period (5-10 per week)
- To effectively follow the nutritional care pathway so that once screened, patients receive appropriate follow up support and treatment, and have the opportunity to improve their nutritional status
- To complete a structured evaluation of the project

3.0 Methods

3.1 Project development and volunteer recruitment

Initial meetings were held between the Wessex AHSN Nutrition in Older People Programme and the CEO of One Community and Lead GP at St Andrew's Practice to agree the approach and scope of the project, and develop a project brief. Wessex AHSN provided funding to the sum of £750 to One Community for the delivery of this six-month pilot project (to support recruitment and provision of resources) using two volunteers to collect the data. A data collection form was developed, along with a nutritional care pathway (flowchart) to give volunteers clear instructions of what to do (see appendix 1 and 2). Volunteers were required to have a DBS check prior to commencing the role.

3.2 Preparation at the GP Practice

The morning chosen for the volunteer to attend was one where a suitable room was available for the volunteer to use. The Practice Manager asked the volunteers to sign a confidentiality agreement and provided a log-in for the computer and EMIS (patient information system) so that height, weight and screening outcome could be recorded on the GP system. An A3 poster was produced to display in the waiting room / reception area to advertise the service. Following feedback from the first volunteer, A6 flyers were produced to give out to the patients to advertise the service. After the first two volunteers left the role, a link person was established (administration assistant) to ensure the volunteer had a key contact in the practice to provide assistance, such as photocopying and administration assistance.

[3] Luger et al. Effects of a Home-Based and Volunteer-Administered Physical Training, Nutritional, and Social Support Program on Malnutrition and Frailty in Older Persons: A Randomized Controlled Trial. Journal of the American Medical Directors Association, 2016. (available from https://www.ncbi.nlm.nih.gov/m/pubmed/27346650/)

[4] http://wessexahsn.org.uk/projects/60/past-projects-our-lessons-learnt

3.3 Training and quality assurance

The volunteers each met with the CEO of One Community to receive information on the background to the project, and the local services offered by the organisation that could be referred into or signposted to. They also received a one-to-one training session with the dietitian (approx. 1.5 hours) using the presentation from the 'voluntary sector training toolkit', part of the OPEN Toolkit[5]. The dietitian also accompanied the first and third volunteer on the first two mornings at the practice to enable the volunteer to initially observe the consultations, and then be observed by the dietitian (the dietitian accompanied the second volunteer on her first morning only, as both volunteers attended together on most subsequent weeks). This included the dietitian observing the measuring techniques used for weighing and taking height. The dietitian also attended the practice to observe the volunteers on another five occasions to check compliance with measuring techniques, MUST screening calculations and adherence to the nutritional care pathway (two occasions with volunteer #1 and three occasions with volunteer #3). The dietitian provided phone and email contact information and was available in case of any enquiries from the volunteer.

3.4 Data collection

Following training, the volunteer attended the practice one morning a week to carry out screening and implement appropriate actions according to the nutritional care pathway. Methods used to encourage patients into the volunteer's clinic varied between volunteers (e.g. one used the flyers, one spoke to everyone in the waiting room, and other patients were asked to see the volunteer by their GP). The process used by volunteer #3 (who was in the role for six months) is outlined in figure 2 in section 4.12. The volunteer used a standard data collection form (appendix 2) to record screening data and actions taken. A form was also developed to record follow up visits, but the volunteer did not use this form and used the standard form instead. A GP referral form (appendix 3) was produced and used by the volunteer to let the GPs know about the outcomes for patients screened and found to have a medium or high risk of malnutrition. An 'alert' form was also produced to alert the GPs if any patients presented with a MUST score ≥ 4. The volunteer attended morning coffee with the GPs in the staff room whenever possible to build rapport and be on hand to provide project updates.

3.5 Evaluation methods

The following methods were used to evaluate the project:

- Data collection forms completed by the volunteer were used to determine undernutrition prevalence, and adherence to the nutritional care pathway (including actions taken, advice and signposting given, follow up data)
- Informal observation of volunteer screening skills by the dietitian during quality assurance visits
- The first two volunteers provided feedback by email after leaving the role
- A dietitian carried out a recorded interview, lasting one hour with the volunteer who was in the surgery the longest (six months) at the end of the project. The purpose of this interview was to obtain feedback on what went well, what could be improved and considerations for running a similar project in the future. Questions were prepared in advance
- Feedback was obtained from the CEO of One Community to obtain feedback on the project
- A survey was provided to all staff in the GP practice (a paper and online version using Survey Monkey) to seek feedback on their awareness of the project. The GPs were asked some different questions to admin staff to draw out finding around patient referrals / giving patients information about the project.

4.0 Results

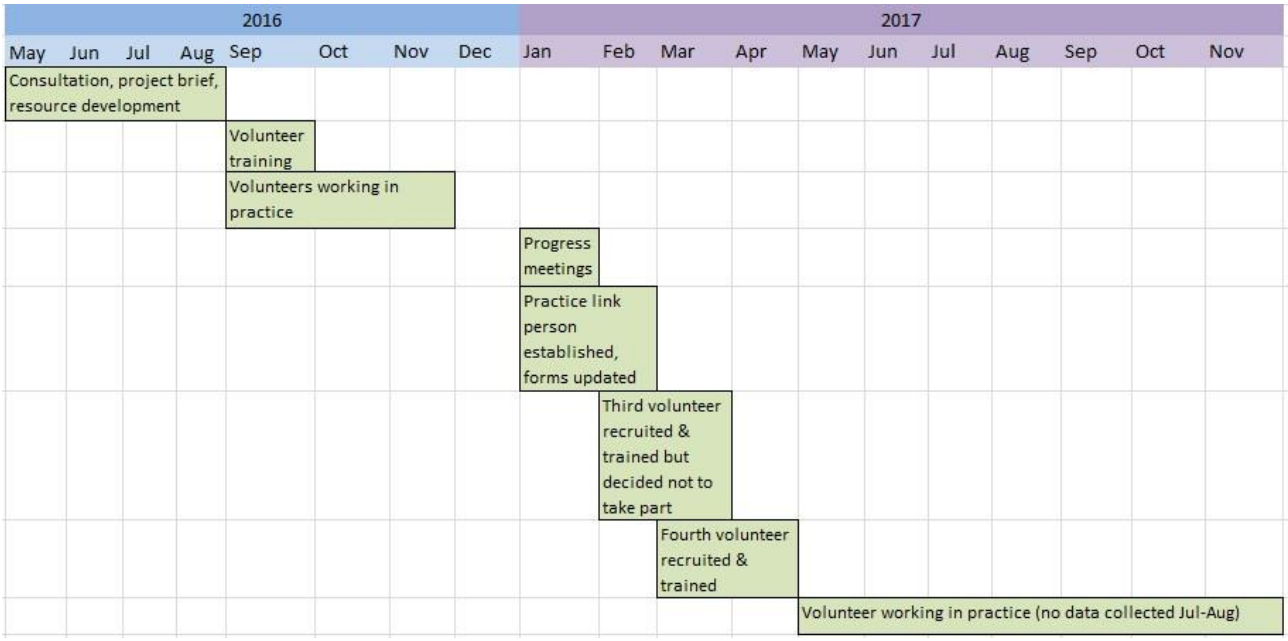
4.1 Recruitment of volunteers

Five volunteers worked on this project (see Figure 1 for timeline). Initially two volunteers were recruited by One Community so they could carry out the screening on alternate weeks / support each other (there was a slight delay between the volunteers starting). One volunteer was new to One Community and the other had been volunteering for One Community in another role. Both volunteers left the role in November 2016. A

[5] http://wessexahsn.org.uk/OPEN-toolkit

third volunteer was recruited by One Community and trained but then decided not to take part. A fourth volunteer was recruited by One Community and trained and started working in the practice between May and November 2017. A fifth volunteer joined the project towards the end in November and carried out some screening under the supervision of the other more experienced volunteer. This final volunteer was recruited because One Community were considering replicating the project in another GP practice and wanted this volunteer to obtain some experience.

Figure 1: *Project timescale*



4.2 Screening by volunteers

A total of 131 screenings were carried out on 121 people. Nine people were screened more than once (eight people were screened twice and one person was screened four times).

4.3 Living status of people screened

The majority of people screened (n=90, 76%) said they did not live alone. 18 people (15%) reported to live alone and no data was recorded for the remaining 13 people.

4.4 Prevalence of undernutrition

Only 6% of people (n=7) were at risk of malnutrition (MUST≥1), with 5 people being at medium risk and 2 people being at high risk of malnutrition. Most of those people who were at risk of malnutrition did not live alone (n=5) (no data recorded for the other two people).

4.5 Wellbeing scores and Malnutrition risk

Wellbeing scores were recorded for 103 people only screened once. The average (mean) wellbeing score was 7.0 (SD 1.4). The mean score differed slightly between those at low risk of malnutrition (n=99) vs those at risk of malnutrition (n=4) (7.1±1.4 vs. 5.5±1.5).

4.6 Actions (information-giving, leaflets, signposting and referrals) made by the volunteer(s) for people at medium and high risk of malnutrition (n=7)

The volunteers were supposed to be giving nutritional information to people who they found to be at medium or high risk of malnutrition, as guided by the nutritional care pathway and data collection form. OPEN nutritional advice leaflets were provided to five people at medium or high risk (71%). The volunteer(s) also gave other information to people with at medium or high risk, such as information about One Community services. Table 1 shows the information / signposting given.

Table 1: *Actions taken for people at medium and high risk of malnutrition (n=7)*

MUST score	Reason for raised MUST score	Time between follow up	MUST score on review	Reasons for underweight / losing weight	Leaflets provided	Other information / advice provided
1	Unintentional weight loss	No follow up arranged	n/a	Queasy, lack of appetite	OPEN leaflet, Dairy Council leaflets	No other information documented
1	Unintentional weight loss		0	Liver cancer. Only eats breakfast and dinner	OPEN leaflet, lifeline	Include lunch, snacks through the day and increase milky drinks
1	Unintentional weight loss		0	Unsure – just discussed with Dr at appointment	OPEN leaflet	Fortified milk, increasing milky drinks, eating little and often
1	Unintentional weight loss		0	Originally wanted to lose weight but then carried on unintentionally	OPEN leaflet	Milky drinks, consider exercise at Fleming Park to help preserve muscle
1	Unintentional weight loss	Declined follow up	n/a	Poor appetite due to back & shoulder pain but now says eating well	OPEN leaflet	Advised to weigh self every 2 weeks at home and visit GP if weight drops further
2	Unintentional weight loss	Declined follow up	n/a	Hip and shoulder replacements and ulcer on lower shin	Dial a ride	Under close observation from Drs
2	BMI less than 20	Declined follow up	n/a	No info	No info	Calcium / bone health

4.7 Leaflets, resources, signposting and other information provided by the volunteer(s) for people at low risk of malnutrition (MUST = 0)

The volunteers also provided advice, information and resources (Table 2) to a number of older people who were at low risk of malnutrition, as well as providing signposting to other local services (Table 3). Verbal or printed information on a variety of One Community services (e.g. lunch clubs and transport services) was provided to 29 people (several people were given information about multiple One Community services).

Table 2: *Leaflets / resources provided for people at low risk of malnutrition (n=114)*

	Number of people
General information about One Community Services	14
British Heart Foundation leaflet on weight loss: either "Eat Better Feel Better: Guide to Weight Loss" or portion size leaflet	12
Dial a ride	5
Lunch Clubs (One Community)	4
Day care services (One Community)	3
OPEN undernutrition leaflet	2
Transport (One Community)	2
Shopmobility (One Community)	2
Shops & Mops (One Community)	1
One Community tea coupon	1

Table 3: *Signposting and information provided for people at low risk of malnutrition (n=114)*

	Number of people
Signposting to local lunch clubs	2
Signposting to visiting schemes	1
Information about Lifeline	1
Information about carer respite	1
Signposting to bereavement support	1
Information about swimming	1

4.9 Follow up

Nine people were screened more than once over the project timescale. The nutritional care pathway specified that all patients with a MUST of ≥ 1 should be offered a follow up session to evaluate the impact achieved by the interventions (e.g. improvement in weight; improvement in well-being; change in what the patient is eating etc). Three of the people with an initial MUST score of 1 received follow up. The other four people with medium / high MUST scores were not followed up (these either declined follow up or were already seeing their GP and were being monitored).

In addition to people at risk, six people with an initial MUST score of 0 (also scored 0 on follow up) were rescreened. No follow up was specifically planned for these people; it is likely that they were simply rescreened due to the opportunistic nature of the project, i.e. the volunteer trying to see as many people ≥65 as possible on the given morning of the clinic slot.

4.10 Cost avoidance results

The additional cost to undertake each nutritional screening is estimated to be £1.84 (NICE 2012). Since screening should already be taking place in accordance with NICE guidelines, this figure has been used to account for additional costs, such as training. Individuals visiting their GP who are undernourished are estimated to incur additional healthcare costs of £1449 per person (Guest et al, 2011[6]), and therefore it is reasoned that for each individual with an improved 'MUST' score there will be a healthcare cost avoidance of £1449.

FOR THIS PROJECT:
Cost of screening @ £1.84 per patient screening = 1.84 x 132 = £242.88
Cost avoidance through improved scores = 1449 x 3 = £4347
TOTAL COST AVOIDANCE FOR THE PROJECT: 4347 – 242.88 = £4104.12

Using data from Hampshire Health Record from 2013-2014, a total of 1151 older people, aged over 65 years were registered at St Andrew's surgery. If we assume a 5% risk of malnutrition, 58 people would be at risk of malnutrition. If 10% risk were used, this equates to 115 patients being at risk of malnutrition.

If screening were to continue at the surgery, there is potential for large cost savings to be achieved. If 80% of registered people over 65 years old were screened (n=921), the cost to screen this population would be £1695.

Assuming a 5% risk of malnutrition among this group the potential cost avoidance would be £42,021 if 50% of those at risk reduced their risk. This would increase to £83,318 if 10% risk of malnutrition is assumed.

[6] Guest J, Panca M, Baeyens J et al. Health economic impact of managing patients following a community-based diagnosis of malnutrition in the UK. Clinical Nutrition, 2011. 30 (4), 422-429.

4.11 Feedback from first two volunteers

Feedback was provided by email from the two volunteers who left the role in November 2016. Quotes from the volunteers were as follows:

- Volunteer #1: "I was not that happy working on my own at the Surgery and having to continually look for suitable people to see"
- Volunteer #2: "I struggled with the level of support and organisation, although they have been as helpful as they can be. I can see that the process could have some value but in a context where subjects could collect the data for themselves and submit it. After a few weeks we have had very few people who have needed to take the advice leaflets. I can't envisage how such a small sample can give any meaningful conclusions"

4.12 Feedback from volunteer #3

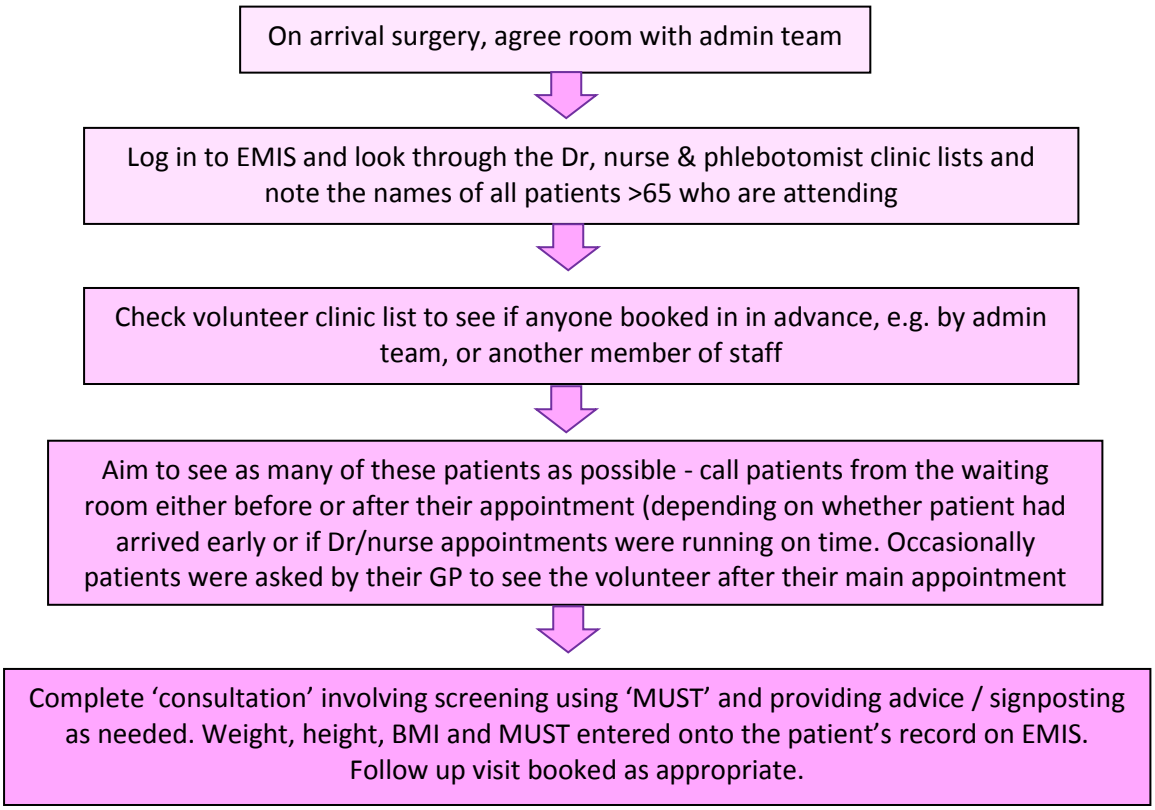
Figure 2 below outlines the process used by volunteer #3 in terms of the set up of the clinic, arrangements for calling in patients and the recording of data. This information was obtained through clinic observation by the dietitian during support visits, and also from the information in the recorded interview. A summary of the additional findings and lessons learnt from the recorded interview are summarised in table 4.

Table 4: *Summary of feedback and lessons learnt from the volunteer (recorded interview)*

Lesson	What went well?	What could be improved? / Recommendations
Organisational support structures are really important for the effective running of the project	• The volunteer had a clear understanding of the purpose of the project and their role • Felt well supported by One Community throughout • The volunteer found the training and support visits by the dietitian very useful • Having a proactive lead GP to keep nutrition on the agenda • Having a link admin staff member to help with admin and EMIS issues	• More effective systems for booking in patients, e.g. Drs and nurses booking in more patients through EMIS; ensuring clinic slot always up to date • Obtaining rapport with GPs was a challenge – keeping nutrition on the agenda is key and systems for reminding GPs of the role of the volunteer would help, e.g. electronic reminders through EMIS
Provision of a toolkit of resources helped to support the project	• The volunteer felt the leaflets / resources provided as part of the project were useful • Data collection form was useful and provided a structure for the consultation	• Volunteer gave OPEN leaflets 'at random' to people not at risk • A postcard to write the patient's weight, height, BMI, MUST score and brief explanation of MUST score would have been useful • A card with useful undernutrition websites could be useful for younger people, e.g. those caring for older people
Getting patients to attend a follow up visit was a challenge	• Patients who were followed up had put into place the advice given and improved	• Some patients declined follow up due to having many other medical appointments

Carrying out undernutrition screening and giving out nutritional advice had some challenges	• Occasional home visits by the volunteer through One Community were useful to follow up on patients and allow them to speak more freely about their issues	• Some 'at risk' patients who attended with carers / family member didn't appear to be able to speak freely about their issues • Volunteer reported to calculate weight loss percentages (and hence weight loss score & MUST score) after the patient had left. However, they felt confident to ascertain if patients had lost significant weight through asking the right questions • Difficult to change habits of a lifetime, e.g. eating / shopping habits and changing eating times • Improving on dealing with people who need support for thing other than undernutrition, e.g. obesity, anxiety, illness
The volunteer brought added value to the surgery by being a 'listening ear'	Volunteer was able to provide a listening ear for people feeling lonely	
The project provided value to the volunteer in terms experience to help support future job prospects		Provision of the letter summarising the work the volunteer has done to provide a 'reference' for future work opportunities

Figure 2: *Flowchart showing the processes used by volunteer at each clinic*



4.13 Feedback from CEO of One Community

The following quote was received from the CEO of One Community about this project:

> "This project served several purposes for our organisation. Firstly, all our staff and volunteers now have a better understanding of the issues of nutrition for the elderly and that One Community had a role to play in at least two of the three we learnt about (advice about social engagement and information about budgeting). Secondly, our volunteers did a great job on a 1:2:1 basis with patients but it took a while for the surgery to understand their role as they were not used to working with volunteers who needed support to understand how the surgery worked. In hindsight, and after our second intake of volunteers, we should have had more comprehensive terms of reference, been able to attend a GP/Staff team meeting, to explain who we were but that was not possible. Lastly, patients understand more about our work and that of the voluntary sector."

4.14 Feedback from staff at St Andrew's Practice

A total of five staff completed the post-project surveys – two completed the online survey and three completed paper versions. Surveys were completed by three GPs and two admin staff. There are 24 members of staff employed by the practice (see figure 3 for breakdown of staff roles), representing a 21% response rate.

One respondent (admin staff) stated there were not aware of the project before completing the survey, and did not provide any information about the service / referrals to any patients. Therefore no information was provided about perceived benefits, negative impacts of value of the project. The other member of admin staff was aware of the project and provided the following responses:

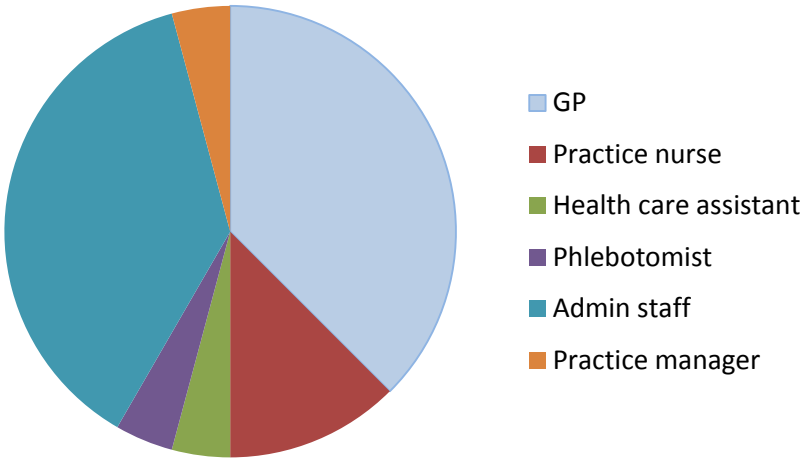
- Provided information to approx. 5-10 patients about the project
- Booked 3-4 patients into EMIS for the volunteer to see (when asked what prompts them to booked the patient in, "if the Doctor / nurse asks" was answered
- None of the patients spoken to had declined to see the volunteer
- Reports to have no asked any patients to see the volunteer. When asked why, responded with "I don't think it's my role to advise patients to see the volunteer"
- When asked what percentage of patients in the practice are at risk of malnutrition, responded with '2%'
- Seen no benefits or negative impacts of the project to date
- When asked about perceived value of the project, answered: "Would be beneficial I think in time once people and staff are more aware of it"
- When asked about how the project could be improved going forward, ticked the boxes for 'Receive clarity on exactly what the project involves' and 'Receive clarity on exactly what the volunteer does'.

A summary of the responses to questions just asked to GPs is as follows:

- 3 GPs stated there were aware of the project before completing the survey
- 2 GPs said their patients had seen the volunteer before their appointment or mentioned they'd seen the volunteer. Both said the thought this had been useful in their care but it didn't flag up risk that they otherwise wouldn't have know about
- 1 GP said that they had asked their patient to visit the volunteer following their appointment. When asked why they had not asked any patients to see the volunteer, one GP ticked the boxes for 'I am unsure of the volunteer's role' and 'I am unsure about what the project involves' and the other stated "They have almost all been caught by the volunteer already!"
- When asked about what percentage of patients in the practice are at risk of malnutrition, responses from the three GPs were: 'don't know' (n=2) and '5%' (n=1)
- One GP stated they had seen benefits of the project to date. When asked to briefly describe these benefits, the GP responded, "Purely awareness, encouraging patient self monitoring". The other two GPs stated they had not seen any benefits

- No GPs said they had seen any negative impacts of the project
- When asked about their perception of the value of the project, three responses were received:
  - "Very useful when targeted"
  - "Unsure"
  - "Little value as far as I can see"
- When asked about how the project could be improved going forward, two GPs ticked the boxes for 'Receive clarity on exactly what the project involves' and 'Receive clarity on exactly what the volunteer does'. One GP ticked the box 'Change the day or time of volunteer's attendance' and also stated "Home visits?? Higher risk of malnutrition in the housebound"
- When asked if they had any further feedback, two GPs provided responses:
  - "If it was possible to vary the days to capture a wider population (with acknowledgement of room availability), that would be helpful"
  - "Evidence of effectiveness would be helpful"

Figure 3: *Staff numbers and roles at the Practice*



5.0 Discussion

Six percent of the older people screened were at medium or high risk of malnutrition; having either experienced recent unexplained weight loss, or being underweight, or both. This figure is similar to the data found in published research, where 5-10% of people visiting their GP practice have been found to be at medium or high risk[7] [8] (prevalence is around 14% for older people living in their own homes[9]).

Having the right volunteer is key to ensure retainment. The volunteer needs to be confident in talking to older people themselves as well as the staff and health professionals within the practice, and be confident in using the computer to enter the screening results into the GP system. They need to understand the issues associated with malnutrition first-hand, e.g. knowing a friend or family member who had suffered also appeared key in getting them on board and understanding the extent of the problem.

It appeared from discussions with the volunteer after the project, however, that more importance was placed on low BMI than unintentional weight loss. This may have been due to the perceived complexity of carrying out screening using MUST, or may have been due to the volunteer's own perceptions or experiences.

[7] Elia M, (on behalf of the Malnutrition Action Group of BAPEN and the NIHR Biomedical Research Centre (Nutrition) Southampton). The cost of malnutrition in England and the potential cost savings from nutritional interventions (full report): BAPEN; 2015.

[8] McGurk P, Cawood A, Walters E, Stratton RJ, Elia M. The burden of malnutrition in general practice. Gut. 2012; 61 (Suppl 2): A18 (OC-042).

[9] Elia M, Stratton R. (2005). Geographical inequalities in nutrient status and risk of malnutrition among English people aged 65y and older. Nutrition; 21:1100-1106

The nutritional care pathway was followed for the majority of people at medium or high risk. This was probably because the pathway itself was clear and understandable, in flowchart format. Training was provided to ensure the volunteers understood how to follow it. All but one person was offered a follow up appointment; this person was seen by the first volunteer who left before following up the person.

The project did not quite meet its aim of screening at least 130 people over the six month period. The likely reason for this is that three different volunteers were involved in screening over the project timescale, and in the early weeks at the practice, the volunteers tended to screen less people as they were still 'learning the ropes'.

Despite the volunteer regularly attending coffee mornings and being available to discuss the project, there did not appear to be a great understanding of the project from the practice staff. This may be due to the staff turnover and vacancies that happened over the course of the project. This included the lead GP and project lead leaving partway through the project. Before the third volunteer started in the practice, a link person (administration assistant) was assigned to help support the volunteer with any administrative or computer issues that came up. This proved to be very useful.

Business case for future projects

Despite only small number of patients being screened as part of this project, and only thee patients improving their score, this still translates to a high potential cost avoidance (£4104.12). As the cost to implement the project was low, and there is potential for high potential cost avoidance figures if the project (or a similar project) was rolled out further (or for a longer period of time), there is a real potential for high cost savings to health and social care, as well as improvements in quality of life for patients.

6.0 Key Recommendations: Considerations for running a similar project in another GP practice

- ***Organisational support*** - having a link person in the GP practice and having a supportive GP to lead the project and facilitate communication to staff in the practice was really important. Carefully planning the systems (including IT software and processes) and advertising (e.g. posters in prominent places) to book in patients / call in patients from the outset would be recommended, to optimise time, to ensure the volunteer feels empowered to carry out the consultation and to enable the patients to understand the role of the volunteer.
- ***Training*** – Providing training to volunteers on the chosen screening method, confidence in starting a conversation around nutrition / making contact with people in the waiting room is important. The Wessex AHSN Nutrition in Older People Programme is planning to further develop their nutrition toolkit[10] to include a volunteer toolkit which will facilitate awareness-raising by voluntary sector organisations themselves, and include training videos.
- ***Recording of data and actions*** – The data collection sheet worked well. Similar projects should consider having data collection methods that ensure ease of use by the volunteer but obtain all relevant information on screening, advice given and follow up to support the business case.
- ***Effective and appropriate signposting*** - A focus on providing good signposting for older people, particularly to services and sectors who run activities and groups to reduce loneliness in older people, which could then impact on improving their nutrition and quality of life. Recording processes for signposting and referrals to specialist services should be considered for future projects.
- ***Investigate use of most appropriate tool for screening*** – Whilst the volunteers used MUST in this project, the Wessex AHSN are currently developing a updated version of the Patients Association Nutrition Checklist[11] and an interactive version (the Nutrition Wheel) which aims to support volunteers to ask some specific questions to determine likely risk of undernutrition and then support a conversation around nutrition, including advice and signposting.

[10] http://wessexahsn.org.uk/OPEN-toolkit

[11] https://www.patients-association.org.uk/wp-content/uploads/2016/12/The-Patients-Association-Nutrition-Checklist.pdf

7.0 Appendices

Appendix 1: Copy of the pathway (flowchart)
Appendix 2: Data collection sheet used in this project
Appendix 3: Copy of the 'alert' / referral forms used to communicate with GPs

May 2018

OPEN Older People's Essential Nutrition

One Community together we make a difference

Wessex Academic Health Science Network

St Andrew's Surgery Eastleigh NHS

Nutritional Care Pathway for use with the Volunteer in St Andrew's Surgery pilot

'MUST' Score 0 Low Risk

1) Offer information on healthy eating & other support **as appropriate**, e.g.

- Provide information on appropriate voluntary services
- Offer information if requested on **healthy eating** - "Eating Well" booklet (British Heart Foundation) or **weight loss** - "Facts not Fads" booklet and/or "Eat better feel better" poster (British Heart Foundation)

2) Ask if they live alone; if so, do they socialise and see friends? If not, suggest clubs and luncheon groups

No further screening or follow up required

'MUST' Score 1 Medium Risk Encourage & observe

'MUST' Score 2 or more High Risk Encourage & take action

Discuss and agree nutrition goals, including:

- Food First advice, including snacks, milky drinks, food fortification advice
- Identify the factors affecting food intake / reasons for being underweight
- Referral or signposting to One Community services
- Provide malnutrition leaflet(s), e.g. OPEN 'Eating well, feeling good', Dairy Council leaflets, Dairy Council postcards
- Record actions on data collection sheet

Complete GP referral form (put completed form in Dr Foy's in-tray for triage). Follow up and repeat 'MUST' monthly
Record actions on data collection sheet

If 'MUST' Score improves, follow the appropriate actions for their new score

If patient declines follow up, complete GP referral form (put in in Dr Foy's in-tray)

If 'MUST' Score stays the same or worsens, review for **2 months** before alerting GP using the referral form (put completed form in Dr Foy's in-tray). Continue to offer support to achieve nutrition goals

ALERT
For a 'MUST' Score 4 or more - Inform GP

Complete a project 'alert' form and put the form in Dr Foy's in-tray

Follow up & repeat 'MUST' monthly. Record actions on data collection sheet

If patient declines follow up, complete GP referral form (put completed form in Dr Foy's in-tray)

Appendix 1

Please contact **Annemarie Aburrow, Dietitian** for assistance with completing the care pathway
Email **Annemarie.aburrow@wessexahsn.net** Tel: **07719 189825**

Appendix 2

St Andrew's Surgery
Eastleigh

Volunteer Name…… **Date used ……**

EMIS code	Current weight	Height	BMI	BMI score (0, 1 or 2)	Amount of unplanned weight loss in last 6 m*	% weight loss	Weight loss score (0, 1 or 2)	'MUST' Score (BMI score + weight loss score)	Wellbeing score (0-10)
Lives alone? (Y/N)	**ONLY COMPLETE THIS BOX IF 'MUST' SCORE IS 1+** What are the **reasons for being underweight / losing weight**? **Brief summary of intake and advice given**. If this is a follow up, what has changed since last appointment?				**Leaflet(s) provided****	**Signposted to / information given on… (please list all)**			**Follow up date**

EMIS code	Current weight	Height	BMI	BMI score (0, 1 or 2)	Amount of unplanned weight loss in last 6 m*	% weight loss	Weight loss score (0, 1 or 2)	'MUST' Score (BMI score + weight loss score)	Wellbeing score (0-10)
Lives alone? (Y/N)	**ONLY COMPLETE THIS BOX IF 'MUST' SCORE IS 1+** What are the **reasons for being underweight / losing weight**? **Brief summary of intake and advice given**. If this is a follow up, what has changed since last appointment?				**Leaflet(s) provided****	**Signposted to / information given on… (please list all)**			**Follow up date**

* Cues: What was their weight 6 months ago? Do their clothes look too big? Do clothes, shoes or rings look loose? Check for loose shirt collars, waistbands, shoes / slippers, rings. Work out the amount of weight lost by asking what their weight was 6 months ago and comparing to today's weight

** If 'MUST' = 1+: provide OPEN leaflet and/or Dairy Council resources. If 'MUST' score = 0, you can provide a leaflet on general healthy eating: "Eating Well" booklet (British Heart Foundation) or if they mention they want to lose weight: "Facts not Fads; Your simple guide to healthy weight loss" and/or "Eat better feel better" poster (British Heart Foundation). In addition, provide One Community information as relevant according to need, regardless of specific 'MUST' score.

Appendix 3

Triage Referral Form: Medium or high risk of malnutrition

Dear Dr Foy

As part of the volunteer project,
…… (name) was screened for malnutrition using the 'MUST' screening tool

Tick & complete which statement applies:

☐ They were found to be at medium / high risk of malnutrition, with a **'MUST' score of …….** Dietary advice and a leaflet on malnutrition has been provided and the patient has ***declined to attend a follow up appointment***

☐ They were found to be at medium / high risk of malnutrition, with a **'MUST' score of …….** Dietary advice has been provided and the patient **is being seen again in …… week's time**

☐ Their 'MUST' score has worsened since initial screening (from …… to ……). ***Whilst we will continue to offer review appointments, please be aware that further support, e.g. oral nutrition support may be appropriate***

☐ They have been seen …… times and their most recent 'MUST' score was …… Dietary advice and follow up has been provided. ***They are no longer being seen as part of this project, so please arrange follow up as appropriate***

One Community Volunteer

St Andrew's Surgery
Eastleigh