The Need for an Integrated Approach for Reducing Undernutrition in Older People Living in the Community

Annemarie Aburrow, Dietitian for the Nutrition in Older People Programme, Wessex Academic Health Science Network, UK

Malnutrition (undernutrition) affects three million people in the UK[1] and is both a cause and a consequence of a range of health conditions and social factors. Recent estimates suggest that the health and social care costs of undernutrition exceed £19 billion a year in England alone.[2]

Good evidence exists for nutritional interventions, such as nutritional screening and monitoring, provision of appropriate nutrition advice and provision of community meal services in community settings.[3, 4, 5, 6] However, despite this evidence, there is a general lack of overall structure, responsibility and ownership, education and training, and communication across different community and healthcare boundaries with regards to nutritional care.[1, 7] There are complex challenges for both commissioners and providers, including:

- Lack of evidence around the importance of commissioning collaborative, joined-up nutritional care means that providers are unable to provide the evidence to support their business case[1, 6, 8]
- Provider management structures and systems that do not facilitate delivery of joined-up nutritional care and the continuity of care across settings[1, 9]
- Widespread lack of education and awareness around undernutrition in the community.[1, 8, 10]

In direct response to these challenges and problems, the Wessex Academic Health Science Network (Wessex AHSN) Nutrition in Older People Programme was launched in 2014. The Programme has specific strategic aims, including addressing the need for an integrated approach to reducing undernutrition among older people in the community, whilst providing evidence to support the business case for the commissioning of good nutritional care.

Why is an integrated approach needed?

Nutritional care is a multidisciplinary responsibility, and the integration of activities between teams and sectors is absolutely essential.[11]

Many community health and social care teams in the UK lack joined-up nutritional care, with teams having their own ways of working to address nutrition.[12] A person may see several professionals following discharge from hospital, all who may carry out their own screening and care planning, the results of which are rarely shared. Issues also exist around lack of clear referral pathways between teams. There may be several reasons for this, such as different patient record systems (e.g. between GPs and community care teams as seen on the OPEN Eastleigh project), different organisations/trusts operating in the same geographical area, and lack of funding or financial incentive.[8] However, without integrated nutritional care, the care of the older person is seriously compromised. Consider the person who is seen by a community nurse for a few visits to treat a leg ulcer and was screened and given advice due to be being at 'high risk' of undernutrition using the 'Malnutrition Universal Screening Tool' ('MUST').[13] What happens to that person once their visits have ceased? Is anyone informed? Often people assume that the GP takes responsibility, but can primary care practitioners be expected to follow this up when they may lack the skills in treating undernutrition, or feel that it is not their responsibility?

Wessex AHSN integrated approaches

Wessex AHSN's Nutrition in Older People programme has carried out two major projects to date: the OPEN (Older Peoples Essential Nutrition) project and the Dorset Malnutrition project. Both of these projects aimed to evaluate integrated approaches in the identification and treatment of undernutrition.

Pan Dorset Malnutrition Programme

Following the development of the 'Pan Dorset Nutritional Care Strategy for Adults' in 2013, Dorset launched its initial pilot to tackle undernutrition in 2014 (the 'Wool Pilot'). This involved implementing nutritional care pathways for health and social care teams in the community linked to a single GP practice in Purbeck. Following its success, the project was extended across the other five Purbeck GP practices in 2015 and the 'Purbeck Locality Pilot' was established as one of five national Malnutrition Task Force[14] pilots. In early 2016, the project was rolled out into the Christchurch locality, involving a total of 13 GP practices. Due to the positive outputs to date, this integrated approach for community-based undernutrition screening and care is now being rolled out Pan Dorset. Further evidence will be collected and reported on for this Pan Dorset work. Since the publishing of some of Dorset's initial project data,[15] a further 1282 people have been screened for malnutrition (total of 1487 people), of which 27% had a 'MUST' score of 1+. Seventy-five per cent of people screened in the Purbeck and Christchurch pilots had been screened by teams not screening prior to the intervention.

OPEN Eastleigh Project

The OPEN project in Eastleigh, Hampshire, arose from the desire to run a second whole system project (involving change from senior management to front line staff) within Wessex to further test this integrated approach and reduce undernutrition following the NICE guidelines for nutritional support.[16] Staff from different teams (health and social care teams and one pilot local authority care home) received training by dietitians in early 2015, with additional awareness sessions provided to local voluntary sector organisations, community pharmacies and the general public. Following training (which was provided to 145 staff, representing over 80% of the workforce in the pilot area), undernutrition screening data (using 'MUST') was collected for one year from community nursing teams, social care teams, GP practices, and the care home. Support and shadowing opportunities were available from a dietitian during the data collection period. Three hundred and seventy-five people were screened at least once (142 screened more than once), of which 24.5% had a 'MUST' score of 1+.

Lessons learnt from our projects

There are several key learning points from the projects in Dorset and Eastleigh. The following section explores the lessons learnt and looks at the potential solutions to the successful implementation of integrated approaches.

Organisational ownership and senior management support: Ensuring strong team leadership and engagement to establish commitment and involvement by the participating team members is of paramount importance. Organisational support for a policy that forms the basis of the project is also key, particularly where team members are being asked to perform new tasks, or where they may feel it's not their responsibility. In Eastleigh, whilst initial project scoping involved engagement with the local organisations, the project was initiated by the Wessex AHSN rather than being driven by the senior management of the organisations involved. As a result, enthusiasm waned over time as other priorities and organisational changes took place. The development of Dorset's 'Pan Dorset Nutritional Care Strategy for Adults' ensured multi-organisational support facilitating the original pilot, as well as supporting the roll out of the programme Pan Dorset.

Time taken to set up integrated approaches: The time required to engage teams and for the culture to change in order for new processes and systems to be adopted by teams should not be underestimated. It took eight months to set up the OPEN Eastleigh project from initial scoping to the commencement of screening data collection. In Dorset, it has taken over three years from the initial strategy launch to Pan Dorset roll out.

Establish a steering group: Establishing a steering group with clear terms of reference from the outset worked well. In Eastleigh, the steering group become a place to share progress, explore new ideas, and helped build sustainability into the project. Since the formal end of the pilot in May 2016, the group has continued to meet to explore ways to continue good practice.

Identify enthusiastic nutrition champions: Engagement of an enthusiastic nutrition champion within a team helped involve the whole team and maintain team involvement. This worked best when the 'champion' was someone who identified themselves for the role (rather than being selected), following a personal 'encounter' with undernutrition, e.g. a recent case of undernutrition with a family member or client who they actively supported.

Identify most appropriate screening methods for each team: Some teams felt it was not their role to screen using 'MUST'. In addition, there are other workers and non-healthcare professionals, e.g. care agency workers and volunteers who provide support for older people, but for whom 'MUST' screening may not be appropriate. Simple ways of identifying people at risk of undernutrition, along with a tool to support the provision of appropriate guidance/signposting, are currently being explored by the Wessex AHSN.

Provision of resources: Providing relevant, attractive, multidisciplinary team-developed resources helped to support the projects, and led to the spread of good practice. As part of the OPEN Eastleigh project, the OPEN Toolkit was developed, featuring training materials, generic care pathways, awareness materials for the general public and an evaluation framework. The Toolkit is endorsed by the British Dietetic Association. Materials are available to download from: **wessexahsn.org.uk/OPEN-toolkit**.

Awareness training: The provision of undernutrition training was very well received by staff and led to increased awareness and screening. Ways of improving access to training should be considered; the Wessex AHSN is currently producing some training videos as part of its OPEN Toolkit.

Recording methods: In Dorset, an electronic form was developed to record screening and care planning. This form ensures that accurate and complete data is inputted, and leads the user through the nutritional care pathway, suggesting referral routes as required. The use of this electronic form enables information to be shared between professionals and teams. Out of necessity, paper forms were used for the OPEN Eastleigh project, which had limitations such as inaccurate or incomplete forms and did not facilitate the sharing of information between teams.

Exploring alternative roles to lead on nutrition screening within GP practices: Whilst training was provided to GPs and practice nurses, both the Dorset and Eastleigh projects experienced difficulty engaging with GP practices due to competing priorities and lack of prioritisation. Alternative roles could be considered to coordinate nutrition screening, e.g. integrated care teams or community nutrition teams. It is also important to agree a referral route into the GP practice at the outset, for the occasions when input from a GP or practice nurse is needed.

Exploring the role of volunteers: Many older people at risk of undernutrition do not access formal health and social care, but may engage with services provided by the voluntary sector (some of which were trained as part of the OPEN Eastleigh project). A potential benefit of volunteer involvement is their unique role in being able to interact with people in their communities, many of whom are 'hard to reach' and would not necessarily have regular contact with healthcare professionals. Many volunteers also hold positions of influence, knowledge and trust among older people in their community. Over the past year, the Wessex AHSN has been evaluating the potential role of volunteers, with two key projects being undertaken.

The first is having a volunteer from One Community in Eastleigh (a charity focusing on providing services and support to older people in the community) being present in a GP practice for one morning a week to screen older people using 'MUST' and provide basic advice and signposting. As well as collecting undernutrition prevalence data, this project is looking at whether volunteers could have a role in supporting GPs and nurses in screening. The second project involved the provision of training, which included identification of unintentional weight loss, giving basic dietary advice, signposting and how to use the PaperWeight Nutrition Armbands[17] to Age Concern Hampshire volunteers. Whilst the Armbands seemed to act as a prop to help volunteers start a conversation about nutrition, the volunteers tended to use them in isolation rather than in combination with questions to identify unintentional weight loss.[18] A follow up focus group is being held to explore this further.

The role of volunteers is certainly an area requiring more evaluation. Referral routes into voluntary sector organisations (as well as routes back out) should also be explored when looking to establish an integrated approach.

Conclusions

The projects funded by the Wessex AHSN have successfully generated evidence and outcome measures around the importance of good nutritional care for older people in the community, as well as potential cost saving data which could be used for commissioners and providers alike. From the results and outcomes of the projects in Dorset and Eastleigh, it is clear that ongoing work needs to be done to obtain a truly integrated system which can withstand organisational change and ongoing competing priorities.

Health or social care professionals wishing to explore or set up an integrated project in their area should review each of the 'lessons learnt' (detailed above) as part of the project planning and scoping stage. A good starting point for anyone involved in the management of undernutrition in the community is to provide or promote access to education about the importance of timely identification and treatment of undernutrition. The Wessex AHSN OPEN Toolkit (wessexahsn.org.uk/OPEN-toolkit) contains a range of training resources specifically aimed at staff working in the community.

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