Nutrition in Older People Programme
Lessons Learnt from Community Integrated Care Nutrition Projects

Introduction

The Wessex AHSN Nutrition in Older People Programme is focused on the prevention and treatment of malnutrition (undernutrition) in older people. The underlying causes of undernutrition may be due to physical, psychological and social causes requiring multiagency integrated (health, social care and voluntary sector) approaches to resolve. 14% of the >65s are undernourished (1 million people in England; 80,000 in Wessex), with 93% of these living in the community (73,000). The cost of treating a malnourished person is 2-3 times that of treating a non-malnourished person: the disproportional healthcare costs due to increased hospital admissions and re-admissions, increased length of stay, increased dependence and care requirement, increased number of GP visits and prescriptions.

Despite national guidelines and suggested pathways for good nutritional care published over the last ten years, the prevalence of malnutrition, along with an aging population, continues to grow. To date nutritional care is generally not commissioned, and the responsibility for implementation falls between many health and social care roles. New Guidance: Commissioning Excellent Nutrition and Hydration 2015-18 (NHS England, Oct 2015) provides the call to commissioners to make good nutritional care a high priority.

This programme aims to be a catalyst for the implementation of integrated nutritional care in the community care setting for the screening, prevention and treatment of malnutrition in older people; it will support commissioners Wessex-wide to implement good nutritional care that will enable significant impact on both health and wealth creation.

Background

As part of the Nutrition in Older People Programme, two community integrated care projects have been implemented where both health and social care professionals caring for older people in their homes have carried out nutritional screening using the Malnutrition Universal Screening Tool ('MUST') and developed individualised care plans for those older people who are at risk of being undernourished. Both projects are aligned with the NICE Guidance on nutritional support (2006). These projects are:

1. ***Purbeck Malnutrition Project***: In 2013 a Dorset-wide Nutrition Care Strategy for Adults was endorsed by Dorset CCG, Dorset County Council, Dorset Healthcare University NHS Foundation Trust, Dorset Public Health, as well as the unitary councils of Poole and Bournemouth. As the pilot project for the Dorset Malnutrition Programme, this pilot was run across the population of the six GP practices in Purbeck. Health and Social Care team providing care to adults living at

home nutritionally screened their clients, using the 'MUST' screening tool, and those found to be at risk of being undernourished were given an individualised nutritional care plan. An electronic form was used which facilitated the collection of data and calculated the 'MUST' score, as well as guiding the user through the appropriate actions of the nutritional care pathway leading to the provision of individualised care plans, and referrals on to other professionals as outlined in a local nutritional care pathway. The electronic form allows for the sharing of data between the health and social care professionals caring for the same client. The pilot has since been extended to Christchurch and there are plans to roll out the approach across Dorset

2. ***Older Peoples Essential Nutrition (OPEN) Eastleigh Project***: an integrated care project based in Eastleigh, Hampshire. The OPEN project in Eastleigh arose from the desire to run a second whole system project within Wessex to further test the approach of nutritional screening and care being provided by both health and social care teams within the community setting. The geography for this project was agreed through some organisations volunteering themselves and then through engagement with the other organisations that needed to be involved. Local team leads were engaged with, and where possible senior management commitment was also sought. This project was run with the populations of the three GP practices based in Eastleigh town centre as well as with residents in one council run care home. As above, health and social care teams carried out nutritional screening with client, who were over 65 years old and who were living at home or resident in Fleming House Care Home, and provided individualized care plans, based on a local nutritional care pathway, for those older people who were found to be at risk of being undernourished. 'MUST' data was collected using paper forms, and copies of the forms retained in the clients' notes to allow sharing of the information between professionals.

Approach

Project Set Up

For both of these projects meetings were held with the senior management for the participating teams and with the team leads to ensure that the aims for the project was understand as well as their teams involvement, and that there was organisational support for the project. Local project meetings comprising of the team leads were set up to enable progress to be reviewed and any issues to be resolved.

Local processes were reviewed with the team leads and the nutritional care pathways reviewed and updated to reflect aspects of local practice. These pathways were agreed with the local teams.

The members of the health and social care teams taking part in the projects were all provided with training on undernourishment in older people, nutritional ('MUST') screening, and the use of the data collection approach being adopted for each project.

Data Collection

In the Purbeck pilot, the nutrition screening and care planning data was collected electronically. The data could therefore be extracted on a monthly basis, and analysis was carried out by Dorset Public Health. For the OPEN project in Eastleigh, the team members completed paper nutritional screening

and care planning forms. These forms were collected by the project dietitian and collated onto a project database. This data was then reviewed by the project dietetic research expert and analysis carried out by the Wessex AHSN Centre of Implementation Science (CIS).

Identification of lessons learnt and recommendations

During the period of the two projects lessons learnt (positive and negative) were collected by the project teams. Representatives from both projects met on the completion of both projects to consider:

- Similar lessons from both projects, reasons for the lesson, and any recommendations for future projects;
- Lessons from one or other the projects, reasons for the lesson (particularly when it related to a specific from the project design), and any recommendations for future projects.

Lessons learnt and Recommendations

Four main themes are discussed: a) support from the organisation / senior management, b) competing priorities and new takes, c) completion of nutritional screening and d) health outcomes. The following four tables show the lessons learnt for each project, and the associated recommendations according to these main themes.

Table 1: Organisation / Senior Management Support

Lesson	Project	Recommendation
The pan-Dorset Nutritional Care Strategy for Adults has ensured multi-organisational support facilitating the original pilot, as well as helped with engaging the roll-out of the programme to other localities across Dorset	Purbeck Christchurch	**Organisational support for a policy / process change that forms the basis for the project / initiative helps to provide on-going endorsement for the project, even if key members of the team and / or senior management changes. This is particularly true for a project such as these, where team members are being asked to perform a task that may be new to them, and some may feel is not their responsibility** **Ensuring strong team leadership and engagement to ensure commitment and involvement by the participating team members**
The Eastleigh OPEN project was initiated by the Nutrition in Older people programme; the initial scoping of the project involved engagement with the local organisations to seek their involvement. As a result, the project was not driven by the senior management of the organisations involved	Eastleigh	
Even with good organisational support, enthusiasm waned over time as other priorities and organisational changes took place	Purbeck Eastleigh	
Where there was a strong leader providing support for the project, the team where much more likely to adapt to carry out the task even if it was additional to existing tasks	Purbeck	

Table 2: Competing Priorities and new tasks

Lesson	Project	Recommendation
Introducing such a whole system change has required significant cultural change: extension of roles; new participants. Significant time is required to ensure engagement of the participants; also, it took time for this change to be adopted and owned by the teams	Eastleigh	**Significant time and support is required to both set up such a project, and also to allow for changes to become embedded in practice**
Engagement of an enthusiastic nutrition champion within a team helped involvement of the whole team and maintain local team involvement	Purbeck Christchurch Eastleigh	**Identify an enthusiastic nutrition champion in each team and help support and retain engagement and involvement by the team**
Difficult to engage with GP practices due to other care priorities and there are no financial incentive for GP practices to carry out nutritional screening and care planning for under nutrition	Purbeck Christchurch Eastleigh	**Engage with GPs and Practice Nurses about the issues of undernutrition, to obtain their support for screening and care** **Identify alternative roles to lead on the nutritional screening of older people within the GP practice setting (e.g. Care navigators; Transformation Teams; volunteers)** **Agree a referral route into the GP practice (GP or Practice Nurse) for the occasions when their input is needed (e.g. Integrated Care Teams)**
Social Care team did not feel it was their role to complete a full 'MUST' screen	Eastleigh	**Need to find alternative approaches to screening where formal 'MUST' screening is not possible**
Existing health and social care models have many priorities and nutritional screening is often not seen as a key priority	Purbeck Christchurch Eastleigh	**Investigate other routes to providing some simple identification of people at risk and provision of awareness guidance and signposting to services (e.g. use of volunteers; use of basic questions and Paperweight Armband)** **Seek opportunities to raise awareness about undernutrition with the general public**
Many of the older people who are at risk of being under-nourished will not receive formal health or social care	General	

Table 3: Completing Screening

Lesson	Project	Recommendation
Development of an electronic form for the recording of screening and care plans has significantly improved the data collection process. The form used in Dorset ensures that complete and accurate data is entered, and leads the user through the nutritional care pathway, raising referrals as required. Use of the electronic form allowed sharing of the nutritional screening and care plan information between professionals	Purbeck Christchurch	**Where possible implement an electronic approach for recording the screening and care planning which can be shared between professional groups**
Use of the electronic form (outlined above) was in addition to pre-existing patient / client electronic records expected by each organisation. Local agreement is needed with each organisation that their staff will carry out dual entry so that the requirements of both systems are met	Purbeck Christchurch	
Use of paper forms for the recording of nutritional screening and care planning relies on the user accurately completing all of the information required and to correctly follow the agreed nutritional care pathways. Only limited prompts can be provided by the paper forms	Eastleigh	
Use of paper forms does not enforce complete data entry, meaning a number of records may be incomplete or calculations not correct	Eastleigh	
Use of paper forms for recording screening and care planning information does not support information sharing between professionals, unless the records are held at the patients home	Eastleigh	**If using paper recording forms, agree an approach for sharing information between professional teams (e.g. list of those at risk to Integrated Care Team meetings)**
Regular reminders to carry out screening are required since other priorities can come to the fore	Purbeck Christchurch Eastleigh	**Use approaches to help embed the process into normal practice, e.g. coupling to a task they always do (Intentional Rounding); regular reminders**
Need to be able to target those people who are most likely to be at risk	General review	**Identify groups of older people who are most likely to be at risk, e.g. people most at risk of hospital admission; Reablement services; frailty clinics**

Table 4: Health Outcomes

Lesson	Project	Recommendation
Early in both projects it was hoped to be able to translate improvements in nutritional status to more general health outcomes (e.g. reduced number of hospital admissions). In practice this was not possible as the older people involved tend to have complex medical and social aspects to their care, and any positive impact on their care needs were unlikely to show over the limited time periods of the projects (one year)	Purbeck Eastleigh	**Base evidence and business cases for spread of the provision of nutritional screening and care planning on realistic measures, e.g. improved nutritional status,; increased screening and action planning** **Accept that impact on health and social care outcomes need to be assumed, as will estimations of potential cost avoidance**
Health and Social Care teams who carry out the initial screening and care planning, are unlikely to review the patient over a period of time long enough to see an improvement in nutritional status within the community setting		**Ensure that a care pathway is in place with clear referral paths (e.g. to Integrated Care Team) to ensure that on-going are and review of the older person is provided**

Version Control

Date	Version	Name	Comment
14July16	0.1	Kathy Wallis	First Draft
04Jan17	0.2	Annemarie Aburrow	Final changes and formatting completed