

10 Point Plan to improve the management of malnutrition: Summary report

November 2019

Background

Both NICE and NHS England have recognised the need to address the problem of malnutrition with the publication of 'NICE Clinical Guideline 32' and NHS England's 'Guidance - Commissioning Excellent Nutrition and Hydration 2015-2018'.^{1,2}

Poor nutrition in England has an estimated annual cost of £19.6bn of which £15.2bn is NHS costs rather than social care costs.³ More than 3 million people in the UK are estimated to have poor nutrition or are at risk of poor nutrition.⁴ Older people are more at risk with 1.3 million people aged over 65 years having poor nutrition.⁵

Surveys have highlighted the problem of poor nutrition in patients admitted into the healthcare system with malnutrition present in: 1 in 4 adults on admission into

hospital; more than 1 in 3 adults admitted to care homes in the previous 6 months; and, up to 1 in 5 adults on admission to Mental Health Units.⁶

There is good evidence that specific efforts to correct nutrition and hydration problems improve health outcomes, however they often go unrecognised and untreated.²

Once in hospital patients' average length of stay is 3 days longer, mortality rates are high and failed discharges are frequent. NICE has shown that better nutritional care reduces complications and length of stay.²

Despite such overwhelming evidence and evidence-based guidance, malnutrition tends not to be a local priority and the problem is still not being adequately addressed.

Aim

The aim of the project was to develop and test a service improvement framework to prevent malnutrition and reduce its clinical impact across the health and social care system.

Methodology

The service improvement framework was developed through a process of consultation with a range of experts including commissioners, providers (including the independent sector) and patient organisations working across the health and social care system. It was presented at the Westminster Health Forum in August 2016 and then tested over an eight-month period (April-November 2017) in three localities: Essex, Kent and Wiltshire.

An overview of the 10 Point Plan is shown in figure 1.

The first step was to use the framework to review current service and clinical pathways for malnutrition in order to suggest new approaches and ways of working. A service improvement intervention was then implemented and evaluated. This included the introduction of new service initiatives in areas such as patient assessment, training, technology and integrated working. Senior dietitians were key stakeholders involved in each pilot site area to ensure access to professional expertise and oversight.

The focus in the pilot areas differed with Kent, Medway and Wiltshire specifically reviewing and evaluating the nutritional support provided for elderly patients across acute, community, primary care and residential/domiciliary care settings whilst Mid Essex focussed on patients with chronic obstructive pulmonary disease (COPD) across acute, community and primary care settings.

The findings from the pilots informed the development of a comprehensive, multi-organisational patient pathway as well as recommendations for clinical and operational implementation.



Figure 1: Summary of the 10 Point Plan

Findings

A typical patient evaluated through the 10 Point Plan programme had the following characteristics: age 85+; had three or more long term conditions; socially isolated (lives alone) and/or in long term care; high level of frailty; three or more hospital emergency admissions in the last 12 months; and at risk of future admission to hospital.

The malnourished group reviewed during the programme: saw their GP 2.1 times more often than the well-nourished; had three times the number of hospital admissions; stayed in hospital more than three days longer; and, lived with more comorbidities.

Analysis of two patient pathways included in the pilot found that earlier identification and management of malnutrition and dehydration resulted in a 6.6 day reduction in patient length of stay with an associated cost saving of £3,650 per patient. Therefore, for every ten elderly care short stay admissions where the risk of malnutrition and dehydration is identified earlier and managed appropriately, the health economy could save around £36,500 and 66 bed days.

Review of 20 individual patient pathways in pilot sites found that patients with a shorter length of stay in hospital (and consequently a lower unit cost) tended to be: screened on admission to the ward; assessed by a dietitian; diagnosed as being medically malnourished and were appropriately supported with food first fortification (FFF) or prescribed ONS where applicable; were weighed daily; and were discharged as soon as they were medically fit.

Review of end of life pathways found evidence of rapid deterioration and weight loss in patients; for example, those

with dementia and those with pressure sores as a result of malnutrition and dehydration.

The role of the dietitian is often poorly understood by commissioners and means that dietetics has become an easy target for funding cuts and de-prioritisation. In all pilot areas dietitians were recognised as a scarce resource often working in isolation to the wider health and social care teams.

GPs in the pilot sites identified that ONS play a valuable part in reducing the impact of clinical malnutrition but there is a need for clearer clinical pathways for appropriate prescribing of ONS in primary and community care settings. The drive for cost savings has led to some commissioners promoting a FFF blanket approach, which may not be in the best interests of the individual patient at that point in time.

Nursing and residential homes were found to be unable to make direct referrals to dietetic services so there is a need to develop standardised and simplified referral pathways.

The Malnutrition Universal Screening Tool ('MUST') was identified as a useful tool. In Kent, the 'MUST' screening assessment process was incorporated into the electronic patient administration system as a first point of triage and assessment.

However, there is a concern that use of 'MUST' in isolation will not ensure the effective clinical management of complex patients with malnutrition. Feedback by clinicians in the pilot sites identified that the malnutrition assessment ranges do not always reflect the clinical complexities associated with frail elderly patients.

Outputs and Recommendations

There needs to be better screening earlier in the pathway which prevents malnutrition risk or the malnourished state exacerbating. Screening at admission and discharge into and out of all bedded environments needs to be mandated. A simple step would be recording weight of patients on admission and discharge. Discharging medically stable patients earlier into the locality requires nutritional needs to be managed more proactively and comprehensively in a home or community environment.

Appropriate provision of ONS in the community needs to be part of a managed care pathway. Clinical Pharmacists based in general practice could also be utilised to review patient's medication given the impact certain medications have on appetite and hydration and consider the benefit of products such as ONS.

Greater emphasis needs to be placed on: integrating dietitians as part of the core primary community care and social care teams; developing robust triage programmes ensuring that limited dietetic resource is prioritised for those patients who require it the most; and, ensuring caseloads are not disproportionate to commissioned activity levels and are at sustainable levels.

'MUST' is a valuable part of the assessment toolbox but should be used in combination with clinical judgement especially with more complex patients including the frail elderly. 'MUST' should form part of a comprehensive care pathway solution for frail elderly patients rather than a solution in isolation. There is a particular need for ongoing education and training in the Care Home sector regarding malnutrition and appropriate use of 'MUST'.

1 Prevention

Self-care and health coaching	Provide better information to the elderly and their carers in relation to managing the risk of malnutrition and dehydration.
Patient information and signposting	Ensure that regular screening of malnutrition risk is undertaken at the earliest point in the pathway to support the patient, their carer/s and professionals to identify and manage the risk of malnutrition and dehydration.
Undertake more malnutrition screening and assessment in primary care	Utilise the high street presence of the community pharmacist to become a trusted source of advice, support and information. Undertake annual screening as part of the elderly care health checks commissioned and undertaken in GP practices. Use fixed pathway points such as medicines utilisation reviews, health checks and flu jabs as an opportunity to undertake screening.
Dietitian led triage	Align dietitians with general practice through the elderly care health check to help to target intervention and provide more support to patients at the earliest point.
QOF and CQUIN	Align the incentives and levers in this area. QOFs (or equivalent) and CQUINs to mandate for screening and assessment at all points of the pathway.

2 Proactive Treatment and Support

High intensity care	Give dietitians equal status as part of integrated health and social care teams in the community.
Direct referrals	Develop clear referral pathways and expand direct referral routes to areas such as nursing and residential care, NHS 111 / out of hours teams, domiciliary care and community nursing.
Increasing the ambition of intervention	Prioritise low level interventions such as: <ul style="list-style-type: none">– Self-screening and assessment for malnutrition– Using the voluntary sector in areas such as food prompting and targeted visits– Extending social prescribing Upskill a wider range of clinical and care staff and make malnutrition and dehydration everyone's business.
Extending to a wider Multidisciplinary Team approach	In addition to the integrated team approach, the dietitian should be better aligned to specialist teams, particularly given the multi-morbidity impact of malnutrition. For example: <ul style="list-style-type: none">– Dietitians working with palliative care teams (developing a more bespoke assessment programme for patients on an end of life pathway)– Dietitians supporting community geriatricians in their work in the community (one area would be reviews of patients in nursing and residential homes)

3 Supporting Patients and Home

Domiciliary care	Define the role for domiciliary care staff. Support the unpaid carer through extension of social prescribing, provide with the right information at the right time and help them to identify the key risk factors.
Improving information exchange	Improve the quality of information exchange at discharge from hospital and transfer between core services through: <ul style="list-style-type: none">– Standardised referral pathways– Develop online referral forms on existing systems– Request that a minimum data set is applied to discharge summaries– Provide information to ensure appropriate prescribing of ONS– Develop the perfect patient information journey

4 Legacy

Elevating the role of the dietitian	Ensure the senior dietitian is included at the heart of newly developed integrated health and social care teams. Establish nutrition and hydration steering groups for each of the ICS areas.
Training programme	Develop a training and education strategy. Ensure all health and care staff receive training on detecting and managing malnutrition and dehydration as part of their induction.
Enhancing the role of the voluntary sector	Encourage a stronger focus on befriending, food prompting and social prescribing.

Key Performance Indicators

The following key performance indicators (KPI) were developed during the national 10 Point Plan programme and it is recommended that these are adopted by health systems to ensure that not only are they measuring what matters but gain a thorough understanding of the care offered to elderly patients in this area.

Primary Care Assessment

% of patients diagnosed with malnutrition and dehydration that have an active care plan in place.

% of patients over the age of 75 who are receiving their annual screening for nutrition and hydration.

Acute and Community Care

% of patients screened on admission in acute settings.

Number of patients diagnosed with malnutrition and dehydration in acute settings.

% of patients over the age of 75 discharged into home or community settings who are screened within 72 hours of discharge.

On-going Management and Response Times

All community teams compelled to publish average waiting times for access to dietetic services.

% of elderly patients who see a dietitian within 10 days of urgent referral.

The project was led by Conclusio Limited, an independent health care consultancy, and supported by a research grant from the British Specialist Nutrition Association (BSNA). The 10 Point Plan, presented in 2016, is a service improvement framework that was developed to improve the management of malnutrition across health and care systems. The plan was piloted in Kent, Essex and Wiltshire over an eight-month period from April to November 2017.

(1) NICE. Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition. February 2016. (2) NHS England. Guidance – Commissioning Excellent Nutrition and Hydration 2015 - 2018. October 2015. (3) Stratton R, Smith T, Gabe S. BAPEN. Managing malnutrition to improve lives and save money. October 2018 (4) Elia M, Russell CA (Eds). Nutrition Advisory Group on malnutrition led by BAPEN. Combating malnutrition: recommendations for action. 2009 (5) BAPEN. Introduction to malnutrition. What is malnutrition. 2018. (6) Elia M, Russell CA (Eds). BAPEN. Nutrition screening survey in the UK and Republic of Ireland. March 2012.