NUTRICIA
Advanced Medical Nutrition

# The importance of nutrition to the integrated care debate

Chaired by Rt. Hon. Stephen Dorrell

This report has been created by Public Policy Projects in partnership with Nutricia Advanced Medical Nutrition

Public Policy Projects

# About this report

Public Policy Projects

In December 2018, Public Policy Projects hosted a roundtable in Stratford-upon-Avon, Warwickshire to better understand the evolving public policy environment around nutrition (services, products and diagnostics) as the NHS moves towards a much more locally integrated system of delivery. Since then, the NHS published its Long-Term Plan to ensure that in 10 years' time there is a service fit for the future.

As two overlapping spheres of policy – the community (public health, social care) and the acute move closer together, Public Policy Projects uses this report to highlight the benefits of bringing together the various partners in health and care sector to ensure that nutrition policies are prioritised as part of the patient pathway. Given the target of forming a "fully functioning integrated care system (ICS) by 2021, it is important to highlight outcome related benefits of prioritising nutrition and the overall cost savings as part of that prioritisation.

This publication has been produced in partnership with Nutricia and we thank the roundtable attendees and all those who contributed to the production of this report.

Public Policy Projects

## About Public Policy Projects

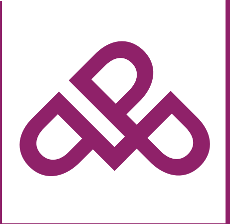
Public Policy Projects (PPP) has a 20-year history of delivering events in the health, care and local government sectors. Public Policy Projects (PPP), chaired by Rt Hon Stephen Dorrell, offers practical policy analysis and development. PPP has hosted speakers including Rt Hon Matt Hancock MP, Rt Hon Jeremy Hunt MP, Andrew Gwynne MP, Simon Stevens, Lord Carter, Professor Dame Sally Davies and many other senior thought leaders. The network consists of senior leaders across the health, care, life sciences and local government sectors. PPP also advises on policy development in health, care, life sciences and local government. The parent company of PPP is Dorson West Ltd.

## About Nutricia Advanced Medical Nutrition

Nutricia pioneers nutritional solutions that help people live longer, more joyful and healthier lives.

Building on more than a century of nutritional research and innovation, Nutricia continues to transform lives through the power of nutrition.

Nutricia's science-based products and services support healthy growth and development during the first 1000 days. Nutricia also helps to address some of the world's biggest health challenges including conditions in early life such as pre-term birth, faltering growth, food allergy and rare metabolic diseases, as well as age-related conditions and chronic disease, such as frailty, cancer, stroke and early Alzheimer's disease.




# Contents

4. Executive Summary

5. Introduction

6. Translating examples of good practice into established ways of working

6. Better nutritional practice

8. Nutrition as part of the pathway

8. Collection of data

10. The medical model of health

10. Education and Training of health professionals

11. A whole system approach

12. Conclusion

13. Recommendations

# Executive Summary

Public Policy Projects

The current policy focus on nutrition, where there is one, refers primarily to overnutrition, due to the prominence of the obesity debate within the public health space. However, this neglects the issues associated with undernutrition (a form of malnutrition), at great cost to both individuals and health services. This paper calls for nutrition and the management of malnutrition to be recognised and implemented as an integral part of care pathways within integrated systems of care.

With the absence of a clear pathway and incentives for providers, nutritional screening and management is not prioritised across the country. Therefore, high levels of under-identification and under-treatment are observed. Further neglect arises from excessive focus being placed on clinical outcomes associated with primary disease processes as opposed to the secondary nutritional effects that can emerge as a result of conditions such as respiratory or gastrointestinal disease.

In certain instances, there is the added issue where nutritional screening takes place, yet minimal or no action is taken, despite a patient having an identified case of malnutrition. The cause of this is partially attributable to a shortage of adequately trained staff across healthcare services, from dietitians to more general healthcare staff, especially in community services. Where malnutrition screening and assessments are carried out, there remains a disconnect with wider teams in primary and hospital services to link with related assessments, such as frailty score. It is clear that work needs to be done to address identifiable links and design a treatment pathway to factor this in.

While the scale of introducing nutritional support in all areas of care may seem overwhelming to commissioners and providers, including a consideration for malnutrition in certain, select pathways, initially with primary care, may give ground for evidence of the benefits to be observed. While sub-optimal for delivering outcomes, this approach may be necessary to gather a sufficient body of evidence to make the case for nutritional inclusion at a broader level. Among interested parties, debates are ongoing over which model to include and how best to measure its effectiveness against others and control benchmarks. While primary care is a natural basis for introducing standardised practice for nutritional support, evolving systems of integrated care enable considerations to transcend siloed service provision and focus more comprehensively on the individual and their care pathway.

There is a disparity between the number of GP practices with a malnutrition risk score on their patient records (1%) and those with enough information on their records for a dietitian to complete a malnutrition risk score (50%). While this creates the opportunity for more advanced analytics to take advantage of malnutrition data in the form of risk scores, a critical mass of data does not exist and standards are not in place to ensure the consistent gathering of data. However, with the national emphasis on prevention and population health data at present, the prospect of embedding a framework for a measurement such as the validated Malnutrition Universal Screening Tool ('MUST') into NHS health checks becomes more likely. In the case of the health check, this is dependent on local authority commissioning and primary care delivery. Uncertainties remain over incentivisation and standardisation to include this and of variance in data across regions and nationally if it is to be commissioned at this level.

The benefits of data and analysis go one step further when combined with the growing field of population health modelling to manage risk and prevent instances of poor nutrition before they manifest into damaging health outcomes. Effective data has the potential to demonstrate the value of nutrition, both in terms of health economics and health outcomes. However, without the necessary mechanisms in place, there will be limited gains in insight and outcomes.

In addition to disease related malnutrition (DRM) there is a cultural and lifestyle element to consider in this debate which impacts upon public health outcomes. Cultural diets and where individuals receive information about nutrition can lead to malnutrition within certain groups. The recognition of this is crucial for the implementation of prevention schemes which could vary in effectiveness between a GP surgery, community pharmacy or religious establishment, depending on where they are delivered.

While there is basic recognition for the importance of managing nutrition in medical school and nursing training programmes, there is scope for this to be integrated as part of educational pathways for all health and social care staff in more depth. Currently, there is insufficient focus placed on regulating this by CQC. However, discussions have begun between the BDA and CQC to investigate where improvements can be made by the regulator.

To deliver on the recommendations of this report, integration must be placed at the heart of all intervention. Trusts need to

recognise the importance of working with primary care and local government and delivering improvements within the community. Due to the connection between good nutritional outcomes and lifestyle factors, a joined-up approach to prevention strategies between local government, health and care services and community services is of paramount importance.

To ensure that nutritional considerations are embedded properly within training, integrated care systems, providers and population health data sets, the Department for Health and Social Care and NHS England must ensure that a clinical lead for nutrition is appointed at a national level, with adequate support regionally from leads covering each of the 44 Integrated Care Systems in England.

# Introduction

Nutrition, and particularly the management of undernutrition, one element of malnutrition, is not currently integral in the care of patients and is not at the forefront of what clinicians are thinking. Malnutrition itself can refer to overnutrition (obesity) as well as undernutrition which can be both disease related and the result of social causes. Disease related malnutrition (DRM) is of particular significance due to a lack of awareness among clinicians about the impacts of the condition and weak integration across health and care pathways, between services. Nutrition support, where mentioned in this report, includes food, dietary advice, oral nutritional supplements, enteral tube feeding, parenteral nutrition.

Malnutrition is a public health problem and is estimated to cost £19.6 billion in England (£23.5 billion in the UK), 15 per cent of total expenditure on health and social care, with older adults (Age 65 and over) accounting for 52 per cent of total costs (BAPEN, 2018). This is set to increase as the population ages. However, while it should be a 'whole system' responsibility, nutrition remains a low priority for the NHS and social care.

When broken down, these costs translate to £15.27bn for healthcare, predominantly secondary care, and £4.36bn for social care. Here, health and care costs are estimated to be three times higher for a malnourished patient (£7,408) than a non-malnourished patient (£2,155).

For several years the British Association of Parenteral and Enteral Nutrition (BAPEN) – a collection of core interest groups – the British Dietetics Association, Malnutrition Task Force, Patients Association, charities, professional organisations, and wider industry, including Nutricia AMN, have been trying to raise the issue of malnutrition (specifically undernutrition), what it is, who it affects and how it can be managed. There is still work to be done, particularly in raising awareness of undernutrition as an issue, when the current focus is on poor nutrition at the other end of the malnutrition spectrum (overnutrition) in terms of obesity.

There needs to be a focus on how to improve the detection and management of malnutrition across health and social care settings in a more integrated way and to improve the communication flows for patients so that when they move into different settings – hospitals, care homes, GP practices, or even a luncheon club – they can be more effectively detected and managed with a range of nutrition support strategies such as dietary advice, oral nutritional supplements and enteral tube feeding.

A priority to strive for is that nutrition, and managing malnutrition, is made integral to care pathways across all care settings. There is a strong evidence base for managing malnutrition effectively – it can improve clinical outcomes and have real health economic benefits. NICE and other health economic analysis has demonstrated that where good nutritional care is implemented it can save money. It is estimated that identifying and treating malnutrition can save at least £123,530 per patient, mainly arising from clinical and cost effectiveness of oral nutritional supplements/ nutrition support. It is crucial to manage malnutrition in the right way, as the largest costs are associated with unmanaged and undetected malnourished patients who are up to 4 times as expensive to treat than well-nourished patients.

As outlined in the BAPEN 2018 report, Managing malnutrition to improve lives and save money, malnutrition is under-identified and under-treated, the consequences of which are poorer clinical outcomes and greater use of health and care services. By establishing a clear pathway and the right incentives, a significant difference can be made to patients and the wider healthcare economy. Currently, the lack of a clear pathway and incentives are major reasons why nutrition is not prioritised uniformly across the country.

# Translating examples of good practice into established ways of working

Public Policy Projects

The scope and influence of nutrition on health and wellbeing is so broad that it can often suffer from an uncoordinated approach in translating individual examples of good practice into national policy. Additionally, nutritional 'failure' often occurs as a secondary phenomenon. Therefore, clinical focus is often on the primary disease process, whether that is respiratory disease or gastrointestinal disease, and the nutritional problems that might arise with those conditions are not recognised by the whole clinical team. This system currently relies on champions of the importance of nutrition e.g. dietetics services or other clinicians who will push the nutrition agenda. It is possible that there may be pockets of excellence in some regions, but this is not disseminated across the system.

When assessing clinical outcomes, a service will measure an outcome related to the primary underlying disease process and not necessarily the secondary nutritional failure that accompanies it. There is a major misunderstanding which likely originates in health professional education, in the sense of not understanding how nutritional care enhances and amplifies the clinical outcomes that a team or service will achieve through their primary disease process pathway.

Across the NHS there has been significant progress in terms of screening and managing malnutrition. Despite this, it often remains under-identified and undertreated across care settings, causing an economic burden. It should be a priority to ensure all frail older people and those with chronic disease are screened for malnutrition risk and subsequent management plans put into place.

Since a validated screening tool such as the Malnutrition Universal Screening Tool ('MUST') was adopted, the amount of screening undertaken by hospital and community teams has increased. However, this has not necessarily resulted in the implementation of action plans – as it should.

Frailty is a good example of where nutrition faces a challenge. There has been major work undertaken across the system to enhance the care facilities provided to frail older people. However, the role of nutrition is still not recognised and does not present a strong voice to integrate nutritional pathways into these very important streams of clinical care. The issue here relates to the design of services around the primary diagnosis rather than the underlying causes or contributors to the condition or disease.

Contrastingly, cystic fibrosis (CF) is a good example of a disease process that recognises the importance of good nutritional support – it has a national framework that sets out how care should be structured, nutrition is properly embedded into the service, and nutritional outcomes form part of the outcome report and benchmarking mechanism for individual services. While positive, this is just one example of where nutrition is properly embedded into a service and where a broad range of professionals are involved in the service not just those specialised in CF. This practice is not replicated across other service areas where a consideration of nutrition could have a positive impact on health outcomes, at present.

# Better nutritional practice

An increased focus on the role of nutrition in improving health outcomes would be particularly beneficial in community services in terms of frailty; including falls and preventing people from requiring hospital treatment. The incidence of malnutrition and frailty in the community is a growing risk, further exacerbated by cultural changes that have increased social isolation and reduced familial and community cohesiveness. In instances such as this, there is an additional social impact, either supplementary to, or instead of, disease related malnutrition which can have equally damaging outcomes. This effect has resulted in a belief that vulnerable people are primarily the responsibility of health and social care services, with an expectation that the voluntary sector will also provide support.

The management of disease related malnutrition (DRM) and social malnutrition need to be considered independently of one another. While the pathways are not fundamentally dissimilar; through screening, identification and the delivery of a management plan, the steps taken in the management plan must reflect the underlying causes of malnutrition and base treatment upon this.

NICE recommends screening and management of malnutrition and even in disease specific guidance nutrition is called out e.g. Chronic Obstructive Pulmonary Disease (COPD) guidance – low BMI – nutrition support. NICE clinical guidelines recommend that if a patient has a low BMI in COPD, consideration of nutritional support should be

Public Policy Projects

given. However, there are not many other examples where consideration of nutrition has been initiated. In addition, there is the widely recognised managing adult malnutrition in the community pathway and managing malnutrition in COPD pathway which, when implemented, has the ability to improve care. While effective, this is not universally implemented and thus potentially results in inequalities in care depending on where an individual lives.

Most incidences of malnutrition originate within the community where healthcare pressures are not properly seen. Even where there are identified respiratory issues and malnutrition is screened for, there is still a risk that patients who are not identified as a concern based on their screening score have other nutritional issues that could lead to malnutrition. This may be the case for patients who are not 'clearly' underweight, for example. There is also a lack of dietitians available, particularly in the community, and other healthcare professionals are either not trained well enough to manage patients' nutritional needs or are not able to act due to the costs associated with doing so.

In addition to screening for malnutrition, frailty assessments should be linked to malnutrition assessments and dietetic services. In Warwickshire STP, for example, services use the Rockwood Frailty Score (RFS) to outline a nutrition and hydration strategy at the nine levels within the RFS. In this part of the Midlands, work is being undertaken with the physiotherapy team to look at what would be the exercise, strength and mobility measures that should be included at each level to link and integrate the processes across the two pathways between frailty teams, hospital teams and the out of hospitals teams. This will ensure that, not only is there work being done by the community teams in the early stages to prevent frailty, but also, once frailty is advanced, that referrals are made into dietetic services and physiotherapy teams for their support in a timely manner.

# Nutrition as part of the pathway

For cystic fibrosis, part of what ensures the value attributed to nutrition is the service specification framework that includes nutritional related outcomes. This reflects the importance of mandated reporting of outcomes and incentives related to nutritional support, which means that there is a value placed on maintaining the quality of professional practice in ensuring nutritional support forms part of a patient's treatment. It is also an issue when raising awareness of nutrition, specifically malnutrition, as an area to be addressed.

The perception of scale for what is involved and where nutrition should be considered can appear overwhelming. It may, therefore, be helpful to begin improving this perception by focussing on conditions as a first step to raising the importance of good nutrition in prevention and treatment of ill health.

From a research perspective, work has been undertaken in community services to demonstrate the benefits that can be secured by implementing good nutritional care. Such research includes implementing the malnutrition pathway in general practice, with some evidence showing a reduction in hospital admissions, readmissions and length of stay, and a good return on investment from a health economics perspective. A much smaller implementation project has been done by applying a managed malnutrition pathway in chronic obstructive airways disease with similar broad results.

In terms of community care, the challenge is how to influence GP clinical practice. This involves the recognition of where GPs have diagnosed, treated or been involved in treating patients who have disease related malnutrition. The question of how to implement a model of nutritional screening and care planning in primary care is key to the broader issue of how to prevent a population of people falling through the gaps that exist in an approach that focusses on the primary condition.

The normalisation of nutritional screening for malnutrition risk, even at a basic level of measuring weight and height, would be a significant improvement. There is the potential to utilise self-screening for malnutrition through technology, which could be made available in GP practices, pharmacies or even supermarkets. This would have the added benefit of promoting the public health message that nutrition is part of everyone's broader healthcare and drive greater engagement by individuals in this element of their health.

Casting the net beyond primary care, South Warwickshire Dietetics has been developing nutrition and hydration standards for care homes and community services, working with Age UK and Alzheimer's Care, and training housing assessors, social care staff, and the fire service to do some basic screening – asking simple questions to identify possible issues.

Raising awareness of nutrition and what to do as an individual if you are malnourished or a patient in your care is malnourished is also vital. Nutrition is a hidden concern for carers, as highlighted in a report from Carers UK. This has been supported by subsequent reports which further highlight the importance of having the right resources available for carers to feel empowered to know what to do in this situation and how to eat well themselves.

# Collection of data

There are numerous ways to collect data, including self-assessment. However, it is important to understand what happens once data is collected to ensure it is of some value. Only 1% of GP practices have a malnutrition risk score on their patient records but 50% of patient records have enough information on them for a dietitian to complete a malnutrition risk score. This presents the potential that, as additional healthcare professionals gain access to GP records, they are able to use this information to estimate malnutrition risk scores. However, despite increased access to data, its usefulness depends on the number of patient records which include a malnutrition risk score, a number which still amounts to a relatively small proportion of all patient records.

The expansion of access to GP records creates an opportunity for greater levels of data analysis in terms of malnutrition risk across different points of contact with health and care services. As national policy places an increasing emphasis on prevention strategies at the regional and local level, as well as closer integration between acute and primary care services, there is an opportunity for nutrition and malnutrition risk data to be incorporated more closely with broader population health datasets, adopting a population health management approach.

For example, there are conversations taking place about embedding the Malnutrition Universal Screening Tool into the EMIS system, but this will likely take some time. Currently,

the population age 40-74 NHS health checks cover BMI, height and weight measurements. This is a mandated service, predominantly carried out through GP practices, that local authorities should be commissioning. There is an opportunity to identify nutrition issues at these health checks, give advice on healthy eating, or suggest further advice should an individual be identified as being at risk of malnutrition.

While local authorities cannot adapt the health check as it is a national programme, they could, in principle, add additional elements to the check for enhanced payment. Guidance states that healthy eating messages and signposting should be part of the basic check. However, GPs often feel they do not have time to deliver an in-depth service and that there is limited benefit to this check as it is unclear how the information is used, if used at all, particularly as the checks take place once every five years.

To overcome this issue, local authorities must be more specific in the service specification they provide to GPs. This must be encouraged, as should the centralised recording of data to allow for reports to be produced and swift action to follow if required. Furthermore, if action is taken as a result of checks delivered through primary care services, the nature and outcome of this could also be recorded. Using population health modelling analysis, there is vast potential for treating existing malnutrition but also preventing future instances, should an effective process be established.

In addition, if the data were linked to the frailty score or 'MUST' score assessments, there may be a more significant benefit for GPs and other health professionals. Health check data is currently linked to the QRISK heart disease scoring but there should be a way to link it to other systems. Currently, if you are over 65, GP practices are supposed to ask patients a question about dementia. Alongside these broader checks, it could be investigated what capacity there is for GPs to gather nutrition and malnutrition risk data.

There is an opportunity to do more in the next cycle of NHS health checks. The Government has pledged it's support for the next five-year cycle of the NHS health check and Public Health England is looking at the programme to see if improvements can be made. This presents an opportunity to include nutrition in the next cycle. Currently, nutrition can be addressed as a local Commissioning for Quality and Innovation (CQUIN) goal. However, this is a temporary improvement measure and becomes difficult to maintain momentum as other priorities are identified.

Creating incentives for cooperation between local government and health services in any aspect of health and care policy is one of the key objectives under the current integration agenda. As local government has responsibility for commissioning and funding the health check and currently neither local government or GPs are seeing a significant improvement in health outcomes, there is a major opportunity to reform the process. The current health check includes a requirement to report on diabetes and hypertension, however, there is scope to include more measures and drive better insight and outcomes.

It is important to get doctors on board. One of the key ways to do this for malnutrition is by recognising the impact on sarcopenia. GPs are hugely important in the process of identifying malnutrition risk. However, the pressure placed upon them by the assessment requirements and information they need to seek is vast.

How do we support GPs to engage in a process rather than expect them to simply deliver a service? Changing this relationship would mean assessments and information found elsewhere could be automatically fed into the GP, enabling them to make treatment decisions. This is not solely about dietitians who also cover large populations, but more broadly for other segments of the health sector with an interest in population health and early intervention.

It is vital, therefore, to secure a proper analysis using data to demonstrate where the problem is, what it costs, what it should look like, and what the health and health economic benefit is so that the key decision makers, particularly in terms of funding, can understand the urgency of the case being made. Effective data also has the potential to demonstrate the value of nutrition, both in terms of health economics and health outcomes, through an analysis of variation in degrees of malnutrition risk. This would be a hugely impactful dataset to collect and analyse.

One of the biggest challenges for improving nutritional outcomes is understanding how to measure variance in nutritional care. With conditions like COPD an outcome can be measured, such as lung function, whereas the specific impact of nutrition alone is more difficult to measure. The Care Quality Commission (CQC) holds data that may support a process of quality assurance in nutritional support services, primarily in social care, which may be a potential way of measuring regional variance. This could be better identified with more robust inspections as best practice examples stemming from Health Information and Quality Authority (HIQA) in Ireland demonstrate.

Public Policy Projects

# The medical model of health

Healthwatch Warwickshire has prioritised developing an understanding of the drivers of good public health for hard to reach, disadvantaged or less-well-known-about groups. There may be lessons to learn from a wider understanding of public health amongst different populations for nutrition. However, public health programmes often do not gain traction in those groups.

The first issue is the cultural aspect of nutrition and how Public Health England or health and care services should engage with those cultural bodies or institutions of importance within the relevant population – for example, the local temple or community centre. It is also vital to understand the social aspect of nutrition; the role of mental health and the personal relationship individuals have with food as part of their heritage, such as where someone has grown up with a specific cuisine.

It is also important to understand where people wish to find out information and receive support on nutrition or lifestyle in general. For example, the formal setting of a GP surgery may not suit many people in learning more about how to maintain good nutrition, whereas, a community pharmacist or local support group may prove to be far more effective. By the same token, the incentive to engage with health services for some people may be the formality of contact with a GP and a request to visit the surgery even if it is not the GP that the patient will see.

# Education and Training of health professionals

There is a substantial lack of attention given to the role of nutrition in the training of healthcare professionals. In medical schools where there is specific training on nutrition, this is very minimal. Meanwhile, for nursing, the role of nutrition is dealt with in disease modules rather than treated as a separate matter. For physiotherapists, who will often work in the community, there is no training as part of their course and while occucapational therapists receive some training, it is focused on the ability of individuals to undertake food preparation and cooking tasks. The social care sector has an equally minimal focus on training in terms of nutrition.

It may, therefore, be helpful to analyse what training is given to health and social care professionals in order to develop guidelines on what should be included in the curriculum and cultivate a wider spectrum of professionals involved in identifying issues that need attention or referral to a dietetics service.

The General Medical Council (GMC) has recognised the need for nutrition education and has convened an advisory group to identify where nutrition should be included in undergraduate and postgraduate training. It will produce a report in 2019 outlining its conclusions. The Council of Deans of Health should also be engaged to understand better how such work could be delivered within Universities.

There is also a role for the Care Quality Commission (CQC) to play in prioritising and assessing the provision of nutrtional support within social care in terms of preventative measures that have the wider health economic

benefit of reducing demand on health services. The current system of evaluation is not addressing the support provided in care homes and does not recognise the issue and impact of malnutrition and hydration amongst care home residents.

The British Dietetic Association (BDA) have met with CQC to discuss training needs and it was agreed that there are a number of key areas such as nutrition, diabetes, paediatrics and mental health where further training is needed but also where inspectors should be looking at as part of routine inspections.

# A whole system approach

In Warwickshire there is clear, systematic engagement and cooperation in nutrition across health, local government, social care, and other public services, such as the fire service, with a fully supported dietetic service working across each of these services. One important element in this region is the role of the South Warwickshire NHS Foundation Trust, acting as an acute and community trust, which has learnt that to reduce admissions it must have good community services. This is a lesson that needs to be accepted by all Trusts, whether they are direct providers of community services or where these are separate.

Joined-up working through place-based hubs with local government is fundamental to the comprehensive provision of services in a given area, driven by a joint vision by health and local authority partners. Given national directives to boost the role and remit of primary care and community services to improve health outcomes for their populations through partnerships and integration, there is an opportunity for dietetics services to be incorporated at the heart of this agenda. For example, the since published NHS Long Term Plan promises an extra 22,000 support staff for GPs by 2023/24 including pharmacists, physician associates and social prescribing workers, who could support this development.

The case should be set out that a particular model which has implemented nutritional considerations and pathways has better overall outcomes compared to models used in other areas. However, the mechanism for building this case is difficult to identify. The Care Quality Commission has identified nutrition and hydration as areas to inspect against but the way

this is carried out could be made more robust by including domiciliary care and general practice inspections alongside care home and hospital inspections, where it is currently used. At the moment, the risks surrounding inspections are that they only take one point in time and will vary depending on who is spoken to within the care environment. There is work to be undertaken to raise the awareness and understanding within CQC about how to assess the quality of care on these terms, and for it to be included for all care setting inspections.

# Conclusion

Nutrition, and particularly the management of malnutrition, is not currently a priority for the NHS and social care providers. While there is considerable work and investment being allocated to reduce the incidence of obesity and the increase in diet related diabetes, malnutrition (undernutrition) is not given the same focus despite its significant impact on health outcomes and its role in the management of other conditions.

It should be a priority for those in health and care to improve the detection and management of malnutrition across health and social care settings in a more integrated way, making managing malnutrition (undernutrition) integral to care pathways, across (and within) care settings. This is based on a strong foundation of evidence suggesting that it can improve clinical outcomes and have a real health economic benefit, aside from improving the quality of life for individuals. NICE and other health economic analysis has demonstrated that where good nutritional care is implemented, including the use of medical nutrition, it can save money. However, health and care professionals do not have sufficient understanding of how nutritional care enhances and amplifies the clinical outcomes that a team or service will achieve through their primary disease process pathway. This is due, in part, to the lack of nutritional education in training and education across professions that must be addressed. Adequate, professional training on the importance of nutrition and managing malnutrition is crucial to allow frameworks to exist and effectively deliver screening and management programmes.

The Care Quality Commission has identified nutrition as an important area to measure. However, measurements should be made more robust and be included in all care setting inspections because there are cases where a care home can pass a CQC inspection regardless of concerns about both nutrition and hydration care and support. There is, therefore, work to be undertaken to raise awareness and understanding within CQC about how to assess the quality of care in these terms. This would enable an overview of what is happening in the management of nutritional care across all care settings and allow comparisons to be made between different geographical areas in order to help address the current inequalities of nutritional care.

Creating incentives for cooperation between local government and health services is one of the key objectives in any aspect of health and care policy. The example of Warwickshire may demonstrate the effectiveness of engagement and cooperation across health, local government, social care, and other public services such as the fire service, in nutrition, with a fully supported dietetic service working across each of these services.

At the same time, purely focussing on a medical model approach to nutrition may result in hard to reach or disadvantaged groups ‘slipping through the net’ and not address why public health programmes do not gain traction amongst those groups. It is important to recognise the cultural aspect of nutrition – and how Public Health England or health and care services should engage with those cultural bodies or institutions of importance within the relevant population group. It is also important to understand the social aspect of nutrition; the personal relationships people have with food, the role of mental health, and where people wish to find out information and receive support about nutrition or lifestyle in general.

Combating this most simply, as mentioned, must include the continuation of local authority commissioned NHS health checks with the addition of nutrition assessments. Combined with a more integrated systems approach aligning frailty score with malnutrition risk, for example, has the scope to alert GPs and other health professionals to the risks, in line with the NHS England and Public Health England prevention agenda.

The question of scaling must be put to NHS England, as well as local authorities, as applicable data analysis must stem from these varying scales within the healthcare sector. The development of Integrated Care Systems (ICS) at a regional level, building on the Sustainability and Transformation Partnership (STP) footprint, opens the door for this and for combined data solutions to be established at a range of scales.

Effective data also has the potential to demonstrate the value of nutrition in both health economics and health outcomes terms through an analysis of variation in levels of malnutrition. This would be a hugely impactful dataset to collect and analyse.

Another challenge for improving nutritional outcomes and understanding how to measure variance in nutritional care is identifying a process for demonstrating the effectiveness of a whole system approach to nutrition. There is a need to enable comparisons of processes and service models with a variance of outcomes that provide a significant case to focus on and invest in treating malnutrition - not only within the health system but also to policy makers at a national level.

Alongside this barrier, there is a wider need to raise the priority of disease related malnutrition (DRM) in primary and secondary care and build an approach to the effective identification and management of DRM to benefit patients and the wider healthcare economy. Given the availability of screening tools and evidence base showing the effectiveness of this malnutrition pathway, the lack of implementation in care services has resulted in DRM being under-detected, under-reported and not managed effectively.

A further issue is insufficient follow-up once a malnutrition screening has taken place due to a lack of documented 'next steps.' This could be addressed through closer integration and incentivisation changes to embed the practice within a whole system approach.

The subsequent publication of the NHS Long Term Plan and its focus on prevention and community services present a positive opportunity to address this challenge. However, to ensure that nutritional considerations are embedded properly within training, integrated care systems, individual providers and population health data sets, the Department for Health and Social Care and NHS England must ensure that a clinical lead for nutrition is created at a national level, with adequate support regionally with leads in each of the 44 Integrated Care Systems in England. The recommendations for delivering improved outcomes, in line with the issues raised in this report, are outlined.

# Recommendations

1. Appoint a clinical lead for nutrition at the Department of Health and Social Care and NHS England with the responsibility and oversight for; the implementation and management of nutritional care pathways, including designing and incentivising nutritional screening tools for primary care providers; training of health and care staff on the importance of nutrition and identifying cases of malnutrition; ensuring regulator compliance in enforcing standardised nutritional practices and pathways; monitoring population health data showing nutritional outcomes; and guidance of all nutritional policy in England.

2. Include a malnutrition risk score in the NHS Health Check as standard for all primary care providers, ensuring that local government commissioning is consistent across regions of England to avoid service and health inequalities. This should also involve the publication of national guidelines for local authorities and the expansion of measures included in the check to adequately cover nutrition.

3. Embed the malnutrition risk score alongside frailty screening for the elderly to address the links between frailty and malnutrition and ensure that older people suffering from frailty and chronic diseases have a management plan implemented. This should subsequently be used as an exemplar of best practice to encourage the uptake of malnutrition screening alongside other care pathways.

4. Include nutritional training in all medical school and nursing undergraduate and postgraduate training programmes as recognised by the GMC. While we await the report from the advisory group on this subject, the Council of Deans of Health should be engaged to understand how to deliver this support in Universities. Inspector training in the CQC should also be improved to better regulated staff nutritional skill.

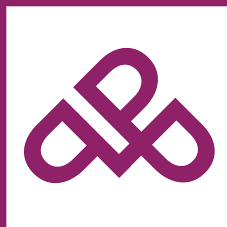
5. Embed support for nutrition within all Integrated Care Systems (ICS) and appoint a clinical lead for each ICS to oversee the implementation of policies in this area as set out by the national lead. System leads should also ensure that all leadership teams developed within the system include a senior dietitian. A study should also be conducted to assess the feasibility of this for newly established Primary Care Networks.

6. Ensure regulatory bodies including CQC include a nutritional consideration in inspections and regulation of health and social care providers, ensuring all staff adhere to NICE clinical guidelines in relation to malnutrition. Develop comprehensive assessment criteria for service providers to assess the management of malnutrition and ensure this forms a core part of CQC inspections.

7. Facilitate a framework and process to enable the effective gathering, management and analysis of malnutrition data, both on a case by case basis for the benefit of individual patients, but also at a system and national scale to support prevention approaches through population health management methods.

8. Implement the Malnutrition Universal Screening Tool (‘MUST’) at identified key points in the patient pathway, ensuring it is used effectively by primary and secondary care providers. Guidance should be published and made accessible to providers, commissioners and care systems to ensure its use effectively.

9. Implement a review of processes to address instances where patients are screened for malnutrition, this is identified, and minimal or no action is taken. A process should be put in place to ensure that in instances such as this, sufficient action is taken to implement a malnutrition care plan for the patient and mitigate the damage to their health outcomes.



Public Policy Projects

Public Policy Projects,
10 Rose & Crown Yard,
St. James's, London, SW1Y 6RE

Tel: 0207 839 9305
**www.publicpolicyprojects.com**