Improvement and Scrutiny Committee – People

Improvement and Scrutiny Review:

Nutrition for Older People in the Community and Care Settings including Hospitals

Final Report

May 2011

Document control – summary of changes	
Final Report 25/05/2011	▪ Version reported to Cabinet ▪ Amended final paragraph on Foreword section to express findings, recommendations and way forward more clearly. ▪ Revised Section 3 to make recommendations clearer ▪ Minor style changes and grammar corrections to all sections
v0.3 12/05/2011	▪ Foreword section included ▪ Minor amendments to document to correct style
v0.2 02/05/2011	▪ Version reported to Committee for approval ▪ Amendments made to style and correction of names of some organisations: Royal Derbyshire Hospitals to Derby Hospitals NHS Foundation Trust ; Adult Care Department to Adult Care
v0.1 28/04/2011	▪ First draft - distributed to people involved in review for comment

Foreword

I am pleased to present this report on the nutrition of older people in the community and care settings including Hospitals across Derbyshire. Whilst it has been a challenging review to undertake it provides a good platform from which we hope health and social care services can work together to make improvements that will be of real benefit to older people across Derbyshire.

We are grateful for the support that we have had in undertaking the review by a wide range of people in health and social care services, as well as the service users we have met with. I would like to extend this acknowledgement to the members of the former Adult Health and Care Improvement and Scrutiny Committee that approved this review in March 2010 and who were subsequently involved in the review process.

The review has taken place during a 'high profile' period with regard to nutrition of older people. Reports such as 'Still Hungry To Be Heard' (Age UK), 'Care and Compassion' (Parliamentary and Health Service Ombudsman) and 'Malnutrition Matters' (BAPEN) have highlighted the poor nutritional status of older people and the failure of services that should have helped them. We have also had to take into account a large amount of research and information that has been produced over the past decade on the effects of poor nutrition among older people.

Whilst it has been disappointing to learn that there is very little information relating to the prevalence of malnutrition in Derbyshire it is hoped that this review will highlight the need for an improvement in this area. Such information is vital to underpin the planning and delivery of health and social care services across the County, particularly when a significant rise in the older population of Derbyshire is expected over the next 20 years.

We have also been fortunate enough to hear about some very good pieces of work that have been undertaken across the County to improve people's nutrition. We hope that by highlighting these examples of good practice other services around the County will make the necessary improvements to help combat poor nutrition in Derbyshire.

The review has made five recommendations that it hopes will secure improvements to health and social care services and ultimately lead to better health and wellbeing outcomes for older people across Derbyshire. These recommendations include the establishment of a joint organisation working group that will lead on implementing four themed recommendations relating to service planning and delivery. These four areas are: Communication, Screening, Training and Development, and Data and Information. The Committee will monitor the progress on these areas and revisit any areas it feels are not making sufficient progress.

Councillor Garry Purdy
Vice-Chairman of the Improvement and Scrutiny Committee – People

Executive Summary

The former Adult Health and Care Improvement and Scrutiny Committee agreed to look at the nutrition of Older People in Derbyshire across a range of health and social care settings at its meeting of 13 May 2010.

The review was prompted by concerns from the Council's Adult Care department over the number of people being admitted to care homes from the community and hospitals who were malnourished.

On investigating this issue further the review learnt that there is little known about the prevalence of malnutrition among older people in Derbyshire – and that this is a similar issue across the Country. Whilst there have been many studies, reports, and campaigns over the past decade or so there is no requirement for social care and health care to work collaboratively in tackling this problem.

During its review work the Committee learnt of some very good work taking place in and around the County by health and social care staff as well as learning of key areas for improvement.

A Nutrition Summit was held towards the end of the review process to present the findings of the review and get the support of health and social care organisations in Derbyshire on the best way forward.

Four recommendation areas have been identified as being integral to ensuring there are positive outcomes from this review:

- Communication;
- Screening;
- Training and Development;
- Data and Information.

The review also recommends that a multi-agency working group is established to oversee the implementation of these four areas. This group will also be responsible for reporting back to the Committee on progress. The Committee will ultimately be responsible for ensuring progress is made and outcomes delivered.

This report details the findings from the review work and the outcomes of the nutrition summit. Whilst this is the end of the review process it is hoped that it is only the start of improving the nutrition of older people in Derbyshire.

Glossary

Word	Definition
BAPEN	▪ The British Association for Parenteral and Enteral Nutrition. It is a multi-professional association and registered charity that was established in 1992.
CQC	▪ Care Quality Commission – the independent regulator of health and social care services in England.
Enteral Nutrition	▪ The feeding of a person via a tube direct to their stomach. ▪ Can be associated with patients who may be unconscious or sedated or with a medical condition that makes it difficult for them to swallow.
MUST	▪ Malnutrition Universal Screening Tool – a clinically designed assessment to detect over and under malnourishment in an individual. Can be used in any healthcare setting and social care settings.
Parenteral Nutrition	▪ The feeding of a person directly into a vein (also known as intravenous). ▪ Generally used when a person cannot be fed through enteral feeding
PEAT	▪ Patient Environment Action Teams – an annual assessment of inpatient healthcare services that have more than 10 beds. ▪ Often undertaken in the form of an inspection or 'walk about' by a team of health professionals and patient representatives (lay people)

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1. Setting the scene

1.1 Reason for the Review

1.1.1 Good nutrition is vital in maintaining good health and wellbeing in an individual. Nutritional requirements alter as a person grows older and the risk of malnutrition increases with age[i].

1.1.2 There is a misconception that as people get older they require less to eat and will naturally become thinner[ii]. It is true that as a person ages so to does their body and its ability to process food and the nutrients it contains. But to ensure that a person remains sufficiently nourished they should have access to a well balanced diet that also takes account of their state of health – there is no 'one size fits all approach'.

1.1.3 Malnutrition, if undetected and untreated can lead to a wide range of adverse effects including:

- Impaired immune response – increasing risk of infection
- Reduced muscle strength and fatigue
- Reduced respiratory muscle function – resulting in increased difficulties in breathing and expectoration (in turn increasing the risk of chest infection and respiratory failure)
- Impaired thermoregulation (Predisposed to hypothermia)
- Impaired wound healing and delayed recovery from illness
- Apathy, depression and self-neglect
- Increased risk of admission to hospital and length of stay[iii]

Poor nutrition, particularly for older people and those with long-term health conditions, increases the risks of infection, falls, and pressure sores[iv].

1.1.4 The purpose of this review was to look at all the factors relating to nutrition and malnutrition of older people in Derbyshire and what role the local Health and Social Care services are providing in ensuring older people receive good nutritional care. As the review progressed the role of hydration alongside nutrition was also included.

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[i] Nazarko, L. (2009) 'Nutrition part 4: anorexia of ageing', *British Journal of Healthcare Assistants*, Vol. 3, no 4, April, p162-165.

[ii] Wilson, L. (2010) 'Personalisation, Nutrition and the Role of Community Meals', The International Longevity Centre – UK, Westminster.

[iii] BAPEN (2003) 'Backgrounder 2: Malnutrition and the wider context', [Online], Available: http://www.bapen.org.uk/res_press_rel9.html (last accessed 24 March 2011).

[iv] Nazarko, L. (2009) 'Nutrition part 4: anorexia of ageing', *British Journal of Healthcare Assistants*, Vol. 3, no 4, April, p162-165.

1.1.5 The review was also an opportunity to explore good work being carried out by Health and Social care staff. The overall aim of the review work has been to identify what areas of nutritional care across Derbyshire need improving in relation to Older People so that fewer people become malnourished and those that do can be cared for and treated effectively. For the purposes of this review the World Health organisation definition of an Older Person has been used i.e. anyone aged 60 or over

1.2 The national picture

1.2.1 In 2008 the Scientific Advisory Committee on Nutrition (SACN) published a report stating that specific population groups were at risk of poor health due to the lack of variety of foods in their diet and a subsequent low nutrient intake – one of these groups was adults aged 65 years and over living in care settings[v]. However, the report also noted that there were issues with the dietary habits of older people who lived independently not eating the recommended allowances of some foods, e.g. fruit and vegetables and oily fish, as well as some instances of low intake of vitamins and minerals.

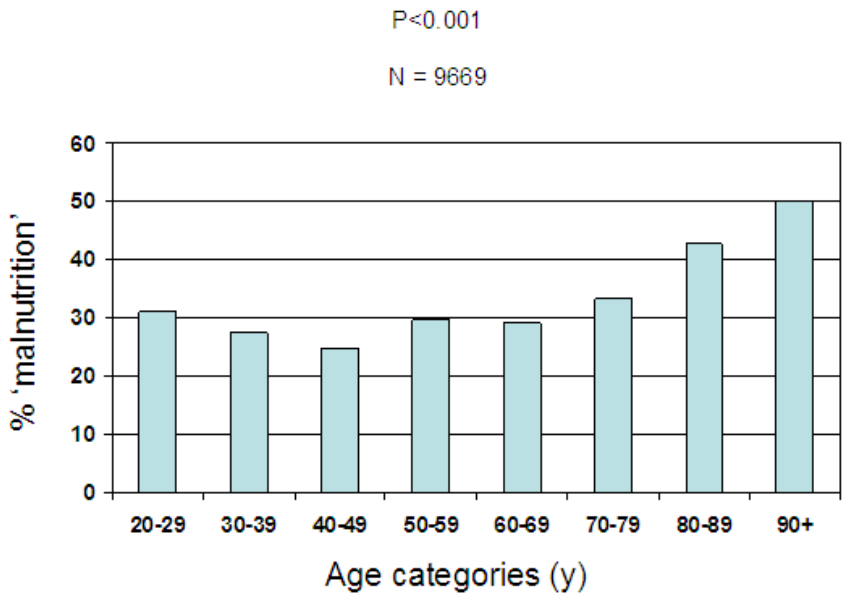
1.2.2 In a report by the British Association for Parenteral and Enteral Nutrition (BAPEN) in 2009[vi] it was reported that disease-related malnutrition is costing health and social care services in the UK over £13 billion per year. The report also suggests that more than three million people in the UK are either malnourished or at risk of malnutrition with the majority of these people living in the community (circa. 93%) and only a small percentage are in care home settings (5%) and hospitals (2%).

1.2.3 BAPEN have also conducted a series of Nutritional Screening Weeks in 2007, 2008, and 2010. The most recent report, for the 2010 survey, highlighted that of the majority of people admitted into hospital who were at risk of malnutrition, 71% came from a person's own home i.e. the community[vii]. Although people across all age-groups are at risk of malnutrition the 2010 survey highlighted that from the age of 60 upwards, the risk of malnutrition increased (see Figure 1 below).

[v] Scientific Advisory Committee on Nutrition (2008) 'The Nutritional Wellbeing of the British Population', The Stationery Office, London.
[vi] Elia, M. and Russell, C.A. (eds.) (2009) 'Combating Malnutrition: Recommendations For Action. A report from the Advisory Group on Malnutrition', BAPEN, Redditch.
[vii] BAPEN (2010) 'Nutrition Screening Survey in the UK and Republic of Ireland in 2010'.

1.2.4 In care homes, malnutrition was detected in only 22% of those under 70 years of age but 36% if aged between 70-84 and 41% if aged over 85. In mental health units, patients were much younger generally but the risk of malnutrition was found to be 30% of those above 65 years of age.

Figure 1: 'Malnutrition' risk according to age in hospitals (BAPEN, 2010)



1.2.5 The BAPEN surveys have been the only regular source of information on the prevalence of malnutrition nationally which is surprising given the seriousness of this topic area. In comparison to a broadly similar issue such as Childhood Obesity there appears to be more statistics and information relating to that than nutrition of older people.

1.2.6 There is clearly a challenge for Health and Social Care organisations in combating malnutrition and related illnesses – whether it is people in the local community or in controlled environments such as care homes or hospitals.

1.2.7 There has been a great deal of work undertaken over many years by various organisations to try and improve nutritional care across health and social care settings. This work ranges from health initiatives, standards for care and guidelines for organisations to take account of. This review has considered a number of these documents (see table 1 below) as part of its research.

Table 1: List of key documents considered by the review relating to nutrition

Year	Document
2010	Essence of Care Benchmarks, *Department for Health*
2010	Still Hungry to Be Heard, *Age UK*
2010	Malnutrition Matters: Meeting Quality Standards in Nutritional Care, *BAPEN*
2010	Personalisation, Nutrition and the Role of Community Meals,

	The International Longevity Centre
2009	Derbyshire Food and Health Needs Assessment, *East Midlands Public Health Observatory*
2007	Guidance on food served to older people in residential care, *Food Standards Agency*
2007	A New Appetite for Life, *Counsel + Care*
2007	Nutritional Screening: Structured Investigation Project, *NHS National Patient Safety Agency*
2007	Water for Health, *Royal College of Nursing and NHS National Patient Safety Agency*
2006	Clinical Guideline 32: Nutrition Support in Adults, *National Institute for Clinical Excellence (NICE)*
2006	Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition, *NICE*
2005	Water for Healthy Ageing, *Water UK*
2004	Eating Well For Older People, *The Caroline Walker Trust*

1.2.8 All of these documents outline the need to make improvements to various aspects of health and social care from leadership and culture changes, through improved screening of patients and support in assisting people with eating, to improving the sharing of information within and between organisations.

1.2.9 Amongst all the guidance documents sits legislation that health and social care services have to be mindful of adhering to. Section 20 of The Health and Social Care Act 2008, for example, sets out regulated activities that health and social care services are monitored on by the independent regulator for this sector – the Care Quality Commission (CQC).

1.2.10 The CQC requires that health and social care providers demonstrate they meet these regulated activities through a registration process. Services have to demonstrate their compliance across 28 'Outcomes' grouped into six key areas. Outcome 5 of the registration process requires services to demonstrate that they are 'Meeting Nutritional Needs'[viii].

1.2.11 The problem with the guidance and legislation is that it is all separate from each other and there is a lack of joining up to make it easier for health and social care services to provide good levels of nutritional care. Although the CQC guidance does at least prompt services to consider many aspects of 'good practice' in relation to nutrition and hydration and not just the minimum standards of care.

[viii] Care Quality Commission (2010) 'Guidance about compliance. Essential standards of quality and safety', London.

1.3 The local picture

1.3.1 As section 1.2 highlights there is a lack of nationally available data on the prevalence of malnutrition in the UK (across all age-groups) and the subsequent impacts this has on health and social care services. At a local level there appears to be even less information.

1.3.2 The review was unable to find any data on the prevalence of malnutrition among older people in Derbyshire. No health or social care services took part in the BAPEN National Screening Weeks so it was not possible to get a set of aggregated results for Derbyshire.

1.3.3 During the review process it was made clear that screening of people admitted to hospitals and other care settings is taking place in Derbyshire but it appears that there is no external reporting of the information collected through this screening. The only reporting is internally within organisations as part of processes such as clinical governance.

1.3.4 Some reporting on improvements to patient care, including nutrition, has been made available in the annual Quality Accounts for some health organisations but not all services report this information at present. Those that do, use information collected as part of the Essence of Care Benchmarks developed by the Department of Health.

1.3.5 All hospital settings in Derbyshire received 'Good' or higher categorisation in the annual Patient Environment Action Team (PEAT) assessments for the 'Food' category in 2010. As part of these assessments an organisations approach to food provision, support for eating, nutrition policies etc is assessed by a group of health professionals and lay representatives with the emphasis being on the patient's view of a service.

1.3.6 However, despite these different reporting methods little information is still known about the prevalence of malnutrition and whether it is issue in Derbyshire – particularly in relation to older people.

1.3.7 The Derbyshire Joint Strategic Needs Assessment (JSNA) is a key component in helping to influence the commissioning of health and social care services in the County. It includes priority areas where health, social care, and local authorities can work together to tackle health inequalities and improve the quality of services.

1.3.8 The JSNA is informed by a large range of national and local datasets so it is perhaps unsurprising that it makes no reference to the nutrition of older people or the prevalence of malnutrition in Derbyshire based on the lack of data this review could find.

1.3.9 However, as the older population of Derbyshire currently accounts for a quarter of the overall population there is perhaps a need to find some method of capturing this information. If the national picture of older people being more at risk of malnutrition is found to be the same at the local level then it will have serious consequences on the effective delivery of health and social care services.

1.3.10 The older population of Derbyshire is also predicted to increase greatly over the next 20 years – some 46% by 2030 (see also Table 2 below) there is an obvious need to ensure that improving the nutritional status of the population is seen as a priority for all health and social care services across the County. Failure to address current issues relating to nutritional care will be exacerbated over the coming years and result in a considerable strain on health and social care services.

Table 2: Older People Population Projection for Derbyshire 2010 to 2030[9]

	2010	2015	2020	2025	2030	Percentage Increase 2010-2030
Age: 60-64	54,400	48,300	51,800	59,900	61,000	12%
Age: 65-69	42,900	52,200	46,500	50,100	58,000	35%
Age: 70-74	33,300	40,000	49,000	43,900	47,500	43%
Age: 75-79	26,700	29,600	36,100	44,400	40,100	50%
Age: 80-84	19,700	21,500	24,900	30,600	37,900	92%
Age: 85-89	12,500	13,500	15,600	19,000	23,700	90%
Age: 90+	6,000	8,400	10,300	13,300	17,700	181%
Total Older Derbyshire Population	195,800	213,500	234,200	261,200	285,900	46%
Total Derbyshire Population	764,700 (25%)*	785,000 (27%)	809,300 (29%)	834,300 (31%)	856,000 (33%)	12% (8%)

*Figures in brackets show percentage of the Derbyshire Population aged 60+.

[9] ONS (2010) '*2008-based Subnational Population Projections. Table 2b: Local authorities and higher administrative areas within East Midlands, West Midlands and the East GORs*', May.

1.4 The review process

1.4.1 The review was undertaken by the former Adult Health and Care Improvement and Scrutiny Committee. A scoping report outlining the remit of the review was agreed at its meeting of 13 May 2010 and a working group of Members was established to conduct the majority of the review work on the Committee's behalf.

1.4.2 During the course of 2010 the review working group met with representatives from the following organisations:

- Chesterfield Royal Hospital NHS Foundation Trust
- Derby Royal Hospitals NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust (formerly the Mental Health Service)
- Derbyshire Community Health Service NHS Trust
- Derbyshire County Council's Adult Care
- NHS Derbyshire County

Information was also provided by Burton Hospitals NHS Foundation Trust and the local Public Health unit (located within NHS Derbyshire County).

1.4.3 The review also included visits to a range of different care settings from medical wards in acute hospitals to care homes and day centres. The majority of the care home and day centre visits took place during the summer of 2010. Members of the former Committee visited each of the eight districts in Derbyshire as part of its work programme to look at Nutrition, Personalisation, and Safeguarding. The Members were able to experience some meal times as well as speak to residents, service users, care assistants and catering staff.

1.4.4 The review process also included a desktop research exercise, as mentioned in sections 1.2 and 1.3 above. The review was also fortunate enough to have access to the library of the University of Stirling. This was made possible following the opening of the Staveley Extra Care Facility in 2010. Derbyshire County Council had received developmental input into the facility by the University's Dementia Services Development Centre.

1.4.5 Derbyshire Local Involvement Network (LINk) also provided some information on patient experience for the review. Members of the review working group also had the opportunity to speak with patients at Chesterfield Royal Hospital during a couple of lunchtime ward observations in September and October 2010.

1.4.6 A ‘Nutrition Summit’ was held on 12 April 2011 to bring together all the representatives from organisations that had been involved in the review process as well as Members of the Committee. Also in attendance was Dr Barry Jones representing BAPEN who discussed malnutrition in the community and health services and the importance of working together to tackle this issue.

1.4.7 This meeting was well attended by health and social care organisations around the County as well as the Chair of the Derbyshire Adults at Risk Partnership and a regional representative from the National Association of Care Caterer’s. There was a clear will from attendees to begin the work to improve services as soon as possible

1.4.8 The aim of the day was to gain an understanding of the issues uncovered by the review, present the areas identified for improvement and agree a way forward from the review that would result in clear outcomes for older people in Derbyshire. The outcome of the nutrition summit was the identification of four key areas for improvement:

- Communication;
- Screening;
- Training and Development;
- Data and Information.

1.4.9 To ensure that work could begin promptly on tackling all of these areas it was agreed by attendees to establish a joint-organisational working group. The following sections provide more detail on what the review found across the different settings and why the four areas were identified.

2. What did we find?

2.1 Hospitals

2.1.1 For the purposes of this section hospitals means acute hospitals. The hospitals referred to in this review are managed by Burton Hospitals NHS Foundation Trust, Chesterfield Royal Hospital Foundation Trust, and Derby Hospitals NHS Foundation Trust.

2.1.2 The review found that all the hospitals involved in the review have procedures in place to screen patients for their nutritional status within 24 hours of admission across all age-ranges. Screening is undertaken in all settings with the Malnutrition Universal Screening Tool (MUST) which was developed by BAPEN. The tool calculates the risk of a patient being malnourished using information about their BMI, weight loss and any acute illness they may be suffering. By inputting this data into MUST a score of 0 (Low Risk) 1 (Medium Risk) or 2 (High Risk) will be provided to determine the risk of malnutrition within a patient. Attached to the scores are a set of care guidelines on suggested practice on how to deal with the individual.

2.1.3 The overall 2010 PEAT results in relation to the 'Food' category rated Derby as 'Excellent' and Burton and Chesterfield as 'Good'. Further analysis of these results showed that Derby was operating between 81%-100% of patients being screened within 24 hours of their nutritional status. This was not the case though for Chesterfield (61%-80%) and Burton (41%-60%). Though it has since been noted that MUST was being introduced into the Burton's Queen's Hospital during 2010 which may have had an affect on the low scoring.

2.1.4 All hospitals operate protected meal times policies across 100% of their wards. Ensuring patients have dedicated meal times free from unnecessary disruption; allowing them time to eat their meals; receive assistance in eating their meal; has increasingly been recognised as an important part of patient care. Age UK, in their 'Hungry to be Heard' campaign, have listed it as one the seven steps to end malnutrition in hospitals.

2.1.5 Results of the CQC's 2009 Adult Inpatient Survey showed that Burton and Chesterfield were offering 'intermediate' levels of service in relation to quality and choice of food compared to Derby which was offering 'best' levels as shown in table 3 below. ('Best' refers to the top 20% and 'Intermediate' the middle 60%).

Table 3: Inpatient Survey Results 2009

	Burton	Chesterfield	Derby	'Best' Threshold
How would you rate the hospital food?	55 (Intermediate)	53 (Intermediate)	61 (Best)	59
Were you offered a choice of food?	88 (Intermediate)	88 (Intermediate)	93 (Best)	89

Source: CQC Inpatient Survey Results 2009.

2.1.6 The quality of food would not appear to be linked to the catering arrangements in place within the hospitals. Both Chesterfield and Derby use external caters that provide pre-cooked meals that are then prepared through reheating or steaming before being served at ward level. Burton, however, has its own in-house catering arrangements i.e. food cooked on site, yet scored below the 'best' threshold.

2.1.7 The review also found that all hospitals have some form of process for identifying patients who require support to eat their food and that some level of support is provided to patients who require help with eating and drinking. The review received information of an award winning project at Derby which had improved the nutritional care of patients and helped to identify the most vulnerable and at risk patients. More information on this project can be found in the case study at the end of this section.

2.1.8 All hospitals reported that they monitor the food intake of patients identified as 'at risk' nutritionally. The review learnt that some hospital Trusts, such as Chesterfield Royal, have also started recording the amount of food patients do not eat using a simple form. This helps staff to determine whether patients are choosing appropriate meals and/or getting appropriate support to eat them. All hospitals also provide snack foods and sandwiches for patients outside set meal teams if required. Some off-ward storage facilities are available at Chesterfield and Burton, provided food is clearly labelled and is appropriate to the patient's dietary requirements. There is no off-ward storage available at Derby.

2.1.9 Multi-disciplinary Nutrition Steering Groups are present at Chesterfield and Derby. These groups are made up of health professionals from different disciplines, e.g. nursing, speech and language, dietetics etc. These groups coordinate the implementation of polices relevant to nutrition and report upwards to the Trust Boards on issues relating to nutritional care. Burton disbanded its nutrition steering group in 2008 in favour of weekly ward nutrition rounds. These involve consultants, pharmacists and dietitians who review patients receiving enteral nutrition support. The same group also meets formally to review patients receiving total parenteral nutrition support and other 'special cases'.

2.1.10 Chesterfield reported on nutrition in relation to patient care in their 2009/10 Quality Account. This was done through their 'nursing metrics' – a series of indicators introduced in 2009 to ensure delivery of high quality nursing care. The results from September 2009 through to March 2010 showed compliance against nutrition indicators rose from 58% to 88%.

2.1.11 Derby reported on nutrition in relation to improvements to basic care in their 2009/10 Quality Account. The Trust managed to achieve a 92% screening rate with MUST during 2009/10. Burton's Quality Account for 2009/10 made reference to work undertaken during the year to improve catering arrangements for people from different communities.

2.1.12 From the information provided to the review from the acute hospitals it is clear that improving the patient experience in relation to nutrition has been seen as important and is also being driven by health professionals within the organisations.

2.1.13 Areas that could be improved were identified as being:

- sharing of information with other organisations, with a particular reference to a patient's care/diet plan following them when they are discharged from hospital;
- ensuring people are given appropriate support to chose and eat meals, and that the meals are of a good quality;
- staff working on the frontline need to have the right training and knowledge to identify those patients that are not coping with their food or are showing signs of malnutrition that might not have been picked up during screening at admission;
- recording of what a patient does not eat and linking to diet/care plans to ensure people are receiving correct food type and appropriate level of assistance in eating;
- the quality of information available to patients before they go into hospital (for planned admissions) and when they are in hospital could be improved with little information on the hospital websites about choice of food and hydration.

Case Study: Nutrition Ward Assistant Project, Derby Hospitals NHS Foundation Trust. Winner of the 'Personalisation of Care' category at the 2010 Patient Experience Network Awards.

The project initially looked at acute older people wards and the acute stroke unit to determine what problems were faced on a daily basis by staff and patients. This work, along with a benchmarking exercise with other NHS organisations highlighted the need to provide specific support in relation to:

- Nutrition intake and knowledge;

- Hydration management;
- Complex and challenging feeding issues;
- Documentation and communication.

As a result of this work the Nutrition Assistants project was developed and following a successful pilot the Nutrition Ward Assistant roles have been created. Benefits following the introduction of this role have been:

- Patients get what they want to eat
- Improved feeding techniques for people with complex swallowing and dementia patients.
- A significant reduction in complaints
- Fluid intake improved
- Reduction in need for artificial nutritional support resulting in reduced risk of discomfort, infection and cost.
- Improved experience for patients and carers
- Assistance with discharge planning.
- Weight loss monitored showing weight maintenance or increases
- Increased energy levels to aid with rehabilitation and mood.
- Improved quality of information and documentation, in particular food and fluid charts

Closer working with speech and language therapists and dietitians has meant more demanding feeding patterns have been implemented. This means the most vulnerable elderly patients get intense care and support at the time they most need it.

Patients are now offered a lot more in between meals through snacks and supplements. This has introduced a social element to the day. Older people also enjoy the company of the assistants during quieter times on the ward.

Nutrition assistants are able to spend in depth time with individuals to build a greater understanding of their needs. This releases time for other professionals such as Speech and Language Therapists to see appropriate referrals.

Source: Derby Hospitals NHS Foundation Trust

2.2 Care Settings

2.2.1 For the purposes of this section care settings refers to care homes managed by Derbyshire County Council, community hospitals managed by Derbyshire Community Health NHS Trust, and mental health units managed by Derbyshire Healthcare NHS Foundation Trust. The review was not able to consider independent care or nursing home providers.

2.2.2 Across the care home and community hospital settings service users/patients are screened using MUST as part of their admission process. Derbyshire Community Health NHS Trust was the first organisation to introduce MUST across all 12 of its Community Hospitals back in 2008 with the County Council's Adult Care following suit based on working relations with the Community health service. Patients admitted to a community hospital should be screened within four hours of admission.

2.2.3 Derbyshire Healthcare NHS Foundation Trust undertakes screening of older patients across its own mental health facilities but it did not use MUST at the time this review took place. (The Trust also has wards at Chesterfield Royal and Royal Derby Hospitals but patients are subject to arrangements of those Trusts in relation to their care). The Trust requires that the screening of patients in mental health services takes place within three days of admission to a ward or after three attendances to a day centre. The screening tool that is used identifies the risk of malnutrition and a patient is also assessed for other complications such as choking/aspiration, behavioural feeding difficulties and independent feeding. Patients are monitored on a monthly basis or sooner should any concern be raised about their health. The review noted that Derbyshire Healthcare NHS Foundation Trust was looking to review the nutritional screening tool being used across its settings.

2.2.4 In terms of internal arrangements in care settings there is a nutrition policy monitoring and development group within Derbyshire Healthcare NHS Foundation Trust which reports to the Director of Nursing and the Clinical Governance Group. Derbyshire Community Health NHS Trust has had a nutrition steering group in place since September 2008 which reports to the Trust Board. Despite the work of these groups and reporting to Clinical Governance and Trust Boards there would appear to be no external reporting of work done with regards to nutritional care by either organisation e.g. their Quality Accounts for 2009/10 only made minor references to PEAT 'Food' scores.

2.2.5 The review also learnt of the work that Derbyshire County Council's Adult Care service has undertaken to improve the nutrition of residents and clients at its care homes and day centres. This work has included the development of a Catering and Domestic Service Procedure document which provides detailed nutritional guidelines based on CQC, Caroline Walker Trust, and Food Standards Agency guides. This document also gives advice on best practice for meal types, calorie intake, and nutrition and is monitored through internal auditing.

2.2.6 The Council also provides a comprehensive training programme for catering and care staff operating in all of its care settings, i.e. in a person's home, in a care home and in a day centre. This includes Chartered Institute of Environmental Health accredited training in nutrition; general training programme on nutrition and well being as part of the staff induction process; basic food and eating well for people with dementia training courses. However, the review learnt that whilst not all courses are mandatory for staff they are accessible if identified as a training need on a Personal Development Plan.

2.2.7 Meal times are viewed as important times of the day by all settings. All of the community hospitals operate protected meal times to reduce disruption on wards. Care homes and Day centres visited by the Committee Members had set meal times that were observed well by staff and residents. These were free from any interruptions and all took place in suitable dining areas which helped to make meal times more appealing to residents.

2.2.8 All settings use freshly cooked meals except for some of the Council run day centres and the mental health wards at Chesterfield Royal and Royal Derby Hospitals which are subject to the catering arrangements of those Trusts (as detailed in section 2.1). Six of the twelve community hospitals have on-site production of meals and the Newholme Hospital in Bakewell also produces its own bread and cakes. There were concerns raised by staff and some service users at council day centres over the perceived reliance on frozen meals rather than fresh produce, particularly for items such as vegetables. A recent CQC inspection of a council care home was prompted by concerns that it was not meeting the nutritional needs of residents under Outcome 5 of the CQC registration framework.

2.2.9 Adult Care and Derbyshire Healthcare NHS Foundation Trust have both involved service users to some degree in shaping menus and helping with food production. Some of the mental health wards have also held theme nights to encourage patients to try different types of food from around the world that they would not normally try. Patients in long-stay mental health services are also surveyed annually for their views on the quality of food to assist in improving the patient experience.

2.2.10 Derbyshire Community Health Service has also developed a nutritional toolkit, originally for patients with a learning disability, which is now being marketed for all services. More information about this can be found in the case study at the end of this section.

2.2.11 The review heard from a representative of the public who was involved in the PEAT assessments within the Community Hospitals that the service being delivered was centred on the patient not the organisation. The comment is backed up by the PEAT 'Food' scores in 2009 for all the Community Hospitals being rated 'Excellent'. The Kingsway Mental Health Hospital was also listed as 'Excellent'. Care Homes and Day Centres are not part of the PEAT assessment.

2.2.12 The review noted several areas for improvement from the meetings and evidence gathered in relation to care settings. The key areas for improvement identified relate to the sharing of information, training and development of staff, and screening of patients/service users to determine if they are at risk of malnutrition. Derbyshire Community Health NHS Trust informed the review that information on a patient's nutritional status does not always follow them on discharge from an acute hospital (there are 13 acute hospitals that regularly discharge patients into Derbyshire). The review was also mindful of the concerns of the Council's Adult Care service about the nutritional status of residents discharged from hospital into their care homes which had prompted this review.

Case Study: Nutritional Toolkit, Derbyshire Community Health Service NHS Trust

Summary: The Nutritional Toolkit is a simple, colourful and interactive tool used to assist children and adults with learning disabilities in making daily decisions about their choice of food. It was developed by the team at the Assessment and Treatment Unit, Ash Green, which is part of the Specialist Learning Disability Service, Derbyshire Community Health Services. The team wanted to give their patients a greater degree of confidence and independence, combined with the opportunity to make more of their own decisions.

The problem: The team noted that their patient group had difficulty choosing their meals from the written menus or making choices from photographs of food. This resulted in meal choices often being made by staff on the patient's behalf. In accordance with "Valuing People" (2001), which sets out the principles of increased communication, choices, inclusion

and person-centred approaches, the team put their patients at the centre of service provision. They encouraged individuals to take control and have a say about what they would like to eat.

The solution: A user–friendly pictorial nutritional toolkit was produced by the team at Ash Green in collaboration with NHS Innovations East Midlands. This kit helped the patient group express their likes and dislikes, and make informed choices about their diet, thereby assisting their education about healthy eating and specialised diets. It is set out with magnetic pictures, photographs and symbols which match to menus. It is safe, durable and easy to clean, considers different dietary requirements and emphasises the Governments '5 A Day' recommendations.

Benefits for Patients: The main benefits have been improvements in patient involvement in food choices and one to one interaction between professionals and patients. It has also enabled the team to bridge the communication gap and respect people's right to make their own choices. The product could also be adapted to assist choice in many other areas of patient care, such as personal hygiene.

The toolkit won the 2005 'Essence of Care' category at the 2005 Nursing Times Awards. Since its introduction into learning disability services the toolkit has been refined and used on wards with older people and dementia and is also available to purchase by other organisations.

Source: NHS Improvement Network East Midland[10] and Derbyshire Community Health NHS Trust.

2.3 The Community

2.3.1 This section refers to the work undertaken by the review to determine what is happening within the community by health and social care services to tackle nutrition issues amongst older people. For the purpose of this review community means people living in their own home and they may be in receipt of support services from health or social care organisations such as a home help, frozen meals service, or a community health nurse.

[10] NHS East Midlands (2011) 'The Nutritional Toolkit – Derbyshire' [Online], Available: http://www.tin.nhs.uk/innovation-nhs-east-midlands/innovation-in-practice/the-nutritional-toolkit-derbyshire/ (last accessed 24 March 2011).

2.3.2 At the Nutrition Summit on 12 April, the review heard from Dr Barry Jones (BAPEN) that malnutrition (at any age) invariably starts in the community and returns to the community. Those people that do come into contact with health or social care services have the opportunity of being screened and having some form of care/diet plan put in place to improve their health and well being. But it is generally only when people are admitted to hospital or a care home that issues such as malnutrition are picked up.

2.3.3 Results from BAPEN's 2010 Nutrition Screening surveys showed that 31% of people admitted to hospital at risk of malnutrition came from the community. It was 30% for admissions to care homes and 23% for admissions to mental health units.

2.3.4 The review learnt that in regards to a person receiving an assessment of need by Derbyshire County Council's Adult Care service there is no screening or assessment of their nutritional status undertaken. In some areas of the County there are informal arrangements with district nurses and GPs whereby some form of assessment may be undertaken but it was not known if this is done using a clinically approved tool such as MUST. The only time when an individual would be assessed for their nutritional status is if pressure sores are identified during their personal assessment.

2.3.5 Anyone in receipt of a social care service from the Council will have a personal plan/record which includes outcomes the individual hopes to achieve by receiving the service such as improving their diet. This plan is called 'My Support Plan' and should be taken by the individual on any visits to a health professional, e.g. GP, or on admission to a hospital or care home though the review learnt that this is not always the case and health professionals do not always know about the plan.

2.3.6 The review also learnt that there is no formal procedure in place for screening the nutritional status of people at a primary care level, i.e. within a GP surgery. In a time when the focus is shifting to prevention of ill health the review found it surprising that there appears to be little being done at a local level to assess people's nutritional status.

2.3.7 The review recognised that people cannot be forced into a screening and that it is not always appropriate to screen people the first time they come in to contact with a health or social care service. It was also noted that the person they come into contact with is not necessarily the right person to undertake the screening. This is not to say that social care staff or other carers are ignorant of an individuals needs and unwilling to help or support someone. The review was made aware of the work a large number of carers (paid and unpaid) provide to older people in their homes from cooking meals to setting up feeding equipment for those unable to eat food. Though being able to spot

the signs of malnutrition should not be the reserve of paid health professionals.

2.3.8 There are signs that can show an individual is at risk of malnutrition that could be spotted by anyone whether they are a paid professional or a relative. People who are in the early stages of dementia are particularly at risk from malnutrition and the review heard a number of cases where people with early stages of dementia would forget to eat meals or if in receipt of a frozen meal service would forget to cook it resulting in family members finding over-stocked freezers.

2.3.9 The review also had sight of a leaflet produced jointly by NHS Leeds Community Healthcare, NHS Leeds, and Leeds City Council as part of a public health awareness campaign entitled "Spotting the signs of malnutrition simple first steps…", which provides useful advice to older people and their carers on what to look for in relation to malnutrition and what to do if they think they or someone they care for might be might be at risk.

2.3.10 The review also heard from the Public Health service with regards to the work it has been doing in Derbyshire. Whilst it appears that there have been no specifically targeted programmes around malnutrition of older people there are a range of programmes that have been operating in relation to healthy eating, reducing health inequalities and promoting active lifestyles that all have a positive impact.

2.3.11 The review was made aware of a report by the East Midlands Public Health Observatory (EMPHO) in 2009 on the food and health needs assessment for Derbyshire. The report was commissioned by the Derbyshire Food and Health Steering Group a countywide multi-disciplinary group including public and environmental health officers. The report focussed on three key areas: knowledge about food and healthy eating, accessibility and affordability of healthy food, and cooking skills and reported on a number of issues facing people across Derbyshire including specific concerns of older people.

2.3.12 The information collected by this report has been used by the Public Health team to inform its activities in improving the health and wellbeing of people across Derbyshire. This has included initiatives such as the establishment of food co-ops in some areas of the county that give people, particularly in rural or deprived areas, easier access to fresh and locally sourced food.

2.3.13 Health Trainer roles have also been developed across the County to promote healthier lifestyles to communities including older people. The health trainers have supported vulnerable people on a one to one basis to encourage them to improve their lifestyles and one of the main areas being improved among older people has been their diet.

2.3.14 The review team were also made aware of the importance of the voluntary sector and the role it plays in supporting older people through activities such as befriending services, live at home schemes and luncheon clubs. The continuation of these services should be viewed as critical in helping to tackle to malnutrition in older people.

2.3.15 Areas for improvement identified by the review in relation to the community related more to the early detection and prevention of poor nutrition among older people through improved awareness raising and signposting of help and support services. Certainly improved screening by social care and primary care services would be beneficial provided suitable training is provided to those required to undertake assessments. There also needs to be better communication and sharing of information between social care, primary and secondary health services to ensure that if malnutrition is found within the community it is treated and does not return to the community.

3. What happens now?

3.1 Areas for improvement

3.1.1 There were four main areas identified during the review process where improvements can be made that will have positive outcomes for older people. These areas are summarised below – the review has not been prescriptive in identifying specific actions for individual services, nor does it wish to recommend a one-size fits all approach. These areas are:

3.1.2 **Communication** – Improvements relating to the theme of communication were identified in a number of areas. One key area for improvement concerns the sharing of patient information between different care settings particularly in relation to care plans or diet plans and ensuring staff know of and ask for any such plans from patients, carers, relatives, other health professionals etc. Health promotion and awareness raising of malnutrition among older people and those that work with/care for older people could be improved to highlight the signs and effects of malnutrition and how to prevent these from occurring through appropriate diet choices.

3.1.3 **Screening** – the review noted that BAPEN's MUST screening assessment is already widely used in Derbyshire and that it should be the screening tool of choice for health and social care services. The review found that little or no screening happens as a matter of routine in the community and that GP and community services should be doing more and have the support to do it. The review also learnt of an early warning system being used in Adult Care assessments that flags up people at risk of a fall, as malnutrition can be a contributory factor to falls the review is keen to test the feasibility of an early warning system for malnutrition.

3.1.4 **Training and development** – the review noted that improvements will only be made if staff of all levels across the various health and social care settings are given access to appropriate training and development. The review would expect to see that any staff involved in the screening of malnutrition among older people are given training on how to use a screening tool and how to operate any relevant equipment. The recent creation of Dignity Champions could provide a link to patients, carers etc unsure of what to expect within a care setting. At the Nutrition Summit the issue of volunteering was raised as something that could be improved, particularly within acute settings. A suggestion was proposed whereby trainees requiring to demonstrate they have undertaken volunteering, as part of their qualifications, could be enlisted with assisting staff on wards during mealtimes.

3.1.5 **Data and Information** – the review was concerned by the lack of data and information currently available to those commissioning (planning) and delivering health and social care services. Whilst this appears to be a national issue rather than something unique to the County, it is hoped that this review can provide the catalyst to securing improved data collection and reporting in Derbyshire. A baseline of malnutrition prevalence will need to be established in Derbyshire across all health and care settings which could be used to benchmark services against nationally available data from BAPEN. The Joint Strategic Needs Assessment should also make reference to the issue of malnutrition and the potential implications this could have on services in the future if left unchallenged. There is also an opportunity for health and social care services to provide more open and transparent reporting of information they already collect around nutrition and hydration of service users/patients e.g. Quality Accounts for health service providers.

3.1.6 At the review's Nutrition Summit it was agreed by Committee members and representatives present of social care and health organisations that a county-wide multi-agency group should be established to develop a detailed action plan based on the four improvement areas and provide update reports to the Committee on the progress and outcomes of its work. This group should initially be administered by the County Council's Adult Care department for a short period of time.

3.2 Recommendations

3.2.1 The Improvement and Scrutiny Committee – People in considering all the information collected during this review process makes the following recommendations in regards to improving nutrition for older people in Derbyshire:

Recommendation 1
That the organisations responsible for commissioning and delivering health and social care services in Derbyshire commit to the formation of a joint working group, with appropriate officer representation, to implement recommendations 2 to 5 of this review.

3.2.2 The role of this group will be to develop and ensure the implementation of an action plan that secures improvements to services across the four key improvement areas identified in this review, namely: Communication, Screening, training and Development, and Data and Information. It will also be responsible for providing progress reports to the Improvement and Scrutiny Committee – People. In the long-term this group could become a best practice group on nutrition issues for related services in Derbyshire.

Recommendation 2

With regards to **Communication** the review recommends improvements should be made, by the organisations responsible for commissioning and delivering health and social care services in Derbyshire, in:

- The promotion of the 'My Support Plan' social care file to all Primary and Secondary health care settings in Derbyshire and the importance to clients in using this file;
- Ensure clear and visible information is available to patients/clients on good nutrition in settings where food and drink is routinely provided
- The transfer, and sharing, of patient MUST scores and related diet/care plans between primary, secondary and social care settings
- The information available on food choice in care homes and for those attending hospitals for elective treatment.

Recommendation 3

With regards to **Screening** the review recommends that the organisations responsible for commissioning and delivering health and social care services in Derbyshire adopt BAPEN's Malnutrition Universal Screening Tool as the sole screening tool across all settings. It is also recommended that:

- Screening of patients/clients is undertaken within 24 hours of admission (where appropriate to do so);
- Consideration is given to the monitoring of food not eaten by patients in hospitals and clients in care homes;
- That fluid charts or records of drinks received by patients/clients are kept up to date and regularly monitored to ensure appropriate hydration levels are met;
- The feasibility of an early warning malnutrition risk assessment tool is developed for use in primary health care and social care settings.

Recommendation 4

- With regards to **Training and Development** of staff on matters relating to nutrition, and hydration, the organisations responsible for commissioning and providing health and social care services in Derbyshire should ensure that:
- Appropriate training is given in relation to the use of MUST and this includes specific training on use and calibration of any specific measuring equipment;
- Awareness raising for staff in frontline health and social care settings on spotting the signs of malnutrition is provided;
- Staff and volunteers involved in assessing older people to eat meals, across all settings, are appropriately trained.
- Consideration be given to the promotion volunteering opportunities in relation to assisting people at meal times in health settings to trainee medical staff.

Recommendation 5
The review recommends that the organisations responsible for commissioning and providing health and social services in Derbyshire make the following improvements in relation to **Data and Information**:

- Establish four (seasonally based) nutrition screening weeks across all settings using the MUST screening tool. Baseline from this information to be used to monitor future impact of improvements in nutrition
- The Derbyshire Joint Strategic Needs Assessment (JSNA) should make reference to the importance of good nutrition and hydration among older people and the associated costs to services and risks to individuals health if left untreated/prevented. When baseline of nutrition data available from screening survey this should also be included within the JSNA.
- Improved reporting on the Essence of Care Benchmarks by health services –possibly through annual Quality Accounts
- More open and transparent reporting on existing monitoring information undertaken by all services in relation to nutrition and hydration including learning from any complaints.

3.3 Conclusions

3.3.1 The review into nutrition of older people across the various social care and health settings in Derbyshire has shown that there is a lot of good work already being undertaken across the county in supporting people with a poor nutritional status. It has also shown, however, that improvements are needed in a number of areas to make the existing good work more effective.

3.3.2 The review has tried to keep in mind the original scoping report in undertaking its work. There are a number of areas where more work would have been helpful to the review particularly in refining the recommendations. However, the Nutrition Summit held on 12 April 2011 was useful in gaining a level of consensus among health and social care service representatives as to the areas for improvement and how best to tackle them to ensure real outcomes are achieved.

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Former Members of the Adult Health and Care Improvement and Scrutiny Committee

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