Feeding Better Outcomes

Practical solutions to tackling malnutrition

The 10 Point Plan for Nutrition and Hydration

Conclusio Ltd
Inspiring Innovation

The 10 Point Plan for Nutrition and Hydration

Changing Practice and Behaviours across Systems

Outcomes and Recommendations from the National 10 Point Plan Programme

James Roach, Conclusio Limited

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Introduction to the 10 Point Plan for the Management of Malnutrition

Changing practice and behaviours across systems.

Aims and Objectives.

The aim of the national 10 Point Plan Programme was to apply the 10 Point Plan Service Improvement Framework for Nutrition and Hydration in 3 Health and Social Care Systems: Essex, Kent and Wiltshire with emphasis on:

- Using the framework to review current service and clinical pathways for malnutrition.
- Apply the framework in live clinical and operational services and pilot the suggested new approaches and ways of working.
- Testing in real time the value of such interventions and the impact they have on improving the overall service offer for patients with malnutrition and, where appropriate, making recommendations for future implementation.
- Understand how dietitians are used in systems and how they can be used to better effect in line with a changing NHS.
- Mapping the current patient pathway and user experience through a range of patient pathway reviews and case studies.
- Using evidence of current service provision to develop an ideal comprehensive patient pathway solution.
- Understanding through action-based learning what is practically possible from an operational and clinical perspective.
- Using evidence from the 3 pilot areas and insight of health and care professionals to develop a set of recommendations.

The 10 Point Plan Service Improvement Framework (see section 4) was developed in partnership with a range of subject matter experts and tested in 3 regional areas: Essex, Kent and Wiltshire.

These areas were chosen because they were at a population and service level akin to emerging STP and ICS areas and, historically had a range of service and operational challenges generated as a result of an inconsistent approach to malnutrition.

> ***"The 10 Point Plan has demonstrated through action and example, what is possible; this approach was credible and in line with the operational and service challenges being faced by Healthcare Professionals in this area."***
>
> **John Niland,**
> **CEO Provide Community Services**

The 10 Point Plan Programme included a wide range of stakeholders:

- Primary care (GPs, Clinical Pharmacists and Community Pharmacists).
- Integrated community services (including Integrated Dietetic Services).
- Acute services (including Acute Dietetic Services).
- Social care and reablement.
- Integrated urgent care services and 111/out of hours services (OOH).
- Nursing and residential care.
- Voluntary sector.
- Patient groups.
- CCGs and system commissioners.
- Medical Nutrition industry.
- National policy groups and regulatory bodies.

Reasons for Implementing the 10 Point Plan:

- The case for change is well documented in this report, but ultimately the reasons for implementing the 10 Point Plan include:
- Testing an evidence-based service improvement framework with healthcare professionals.
- Recognition that malnutrition and the impact of malnutrition across the NHS did not have enough profile.
- Concern that dietitians were not being given sufficient visibility or influence across wider health and care systems.
- The need to develop a proactive intervention approach across Health systems to prevent malnutrition and reduce its clinical impact.
- Changing the point of intervention and developing a new model of prevention in Primary Care.
- Addressing the missed opportunities associated with policy and guidance not being implemented or followed.
- The need to develop impactful policy which is centred on the experiences of the service user and the healthcare professional.
- Develop a more comprehensive patient pathway for the management of malnutrition that could align with emerging Integrated Care Systems and Primary Care Networks.

What is the 10 Point Plan and how was it developed?

The 10 Point Plan is a service improvement framework that was developed to improve the management of malnutrition across health and care systems. The framework was developed by James Roach in consultation with subject matter experts and was presented at the Westminster Health Forum in 2016. It was then launched as an evidence-based service improvement tool against which a number of approaches could be implemented, tested and evaluated.

It was hoped that by applying the framework across 3 regional health and care systems we could ultimately create a multi-organisational, comprehensive care pathway recognised by all sectors, one that could be rolled out in Integrated Care Systems across the country.

Where was the 10 Point Plan Programme undertaken and why?

To test the concept, the plan was piloted in Kent, Essex and Wiltshire over an eight-month period from April to November 2017. These three areas had already invested in redesigning community services, had a high incidence of frail elderly patients, and a prevalence of long-term conditions, such as Chronic Obstructive Pulmonary Disease (COPD). We also worked with organisations who deliver a range of services across primary, community and social care settings so we could seek to build pathway wide solutions to tackle malnutrition at source.

We adopted a pan-sector, comprehensive approach and sought to engage with organisations that understood the issues, were prepared to test and pilot new approaches and hold themselves to account in the process.

In each pilot area we were able to work with system leaders, staff and organisations from across the patient pathway and the wider supply chain. Beyond the traditional health and social care offer, we also engaged directly with the independent sector (nursing, residential and domiciliary care), the voluntary and the private sectors (including the medical nutrition industry). Working closely with senior dietitians in each pilot site area, we were able to ensure that access to the professional expertise of dietitians was available at each stage. This helped to ensure sufficient professional focus and oversight.

The organisations involved are listed at the end of this report.

Each of the pilot areas established a detailed programme plan.

In Kent and Medway and Wiltshire the aim was to review and evaluate the nutritional support provided for elderly patients across acute, community, primary care and residential / domiciliary care settings. The key type of organisations involved in the pilots included:

- Community healthcare providers.
- Adult social care services.
- Integrated 111 and out of hours services.
- Domiciliary care providers.
- Rapid response services.
- Nursing and residential homes.
- Community pharmacists.
- GPs.
- Dietitians.

In Mid Essex, the aim was to review and evaluate the nutritional support provided for patients with COPD across acute, community and primary care settings and put in place a selection of the ideas set out in the framework of the 10 Point Plan. The key organisations involved in the work in Mid Essex included:

- Provide Community Healthcare Services, who were responsible for providing community care (clinical COPD services).
- Mid Essex Hospitals dietetic services, which provides integrated dietetic services for patients with COPD and managed the care pathway from the inpatient stay in hospital.
- Identified care homes and GP practices with a high prevalence of COPD.
- Community pharmacists who are providing a range of patient services in relation to COPD, such as community spirometry.

Engaging with impact and at scale

All the health and care staff involved in the programme welcomed the presence of a clear operational guide with which to plan services and direct innovation. As one senior nurse observed "the 10 Point Plan helps us to move the plan off the page".

"We have to move away from a culture of top down policy being imposed on systems to one of co-production and partnership with health and care professionals: this is the only way we can ensure change is sustainable and solutions are realistic and professionally credible. The 10 Point Plan has demonstrated that this is possible."

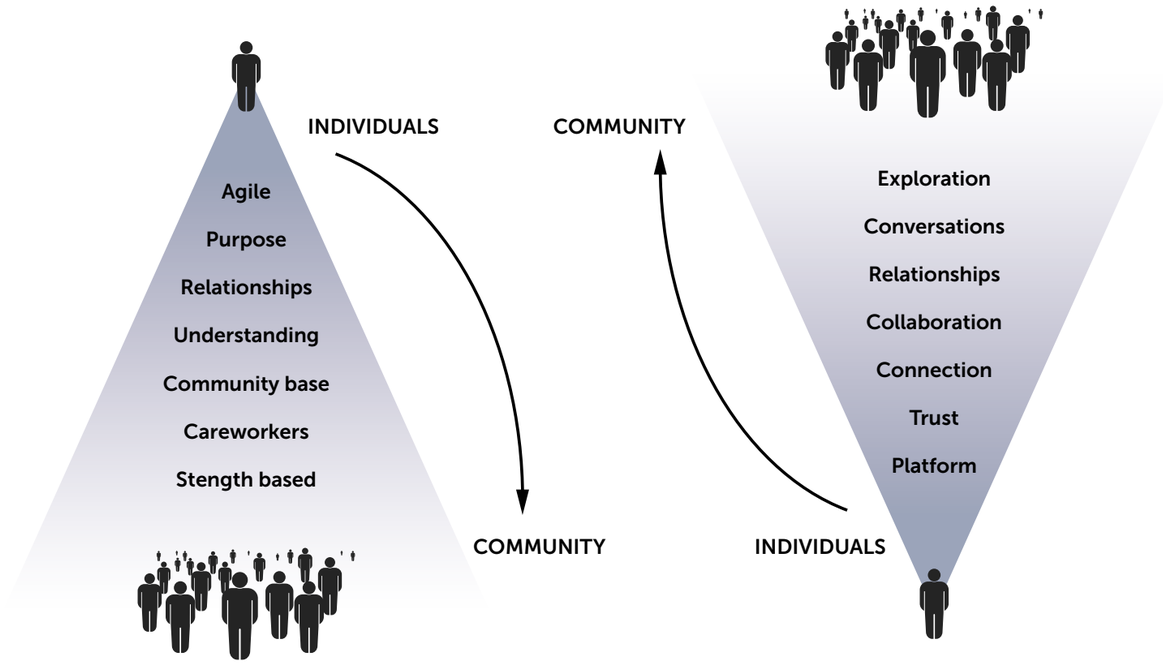
As Jo Howes, Chief Executive of Wiltshire Care Partnership, reflected:

The 10 Point Plan:

- Engaged with providers who collectively provide health and care services for a population in excess of 1.5 million.
- Uniquely pulled together acute hospitals, community services, primary care (GPs and pharmacists), nursing and residential care, domiciliary care, voluntary sector, independent, private sector, patients and relatives into a connected service pilot.
- Engaged directly with individual nursing and residential homes.
- Engaged with over 250 front-line professionals (covering a range of disciplines).
- Put in place a range of new service initiatives in areas such as assessment, training, technology and integrated working.
- Engaged a range of patient organisations to ensure that the patient and carer view was at the heart of all activity.
- Left a strong legacy for change and improvement locally, nationally and, perhaps more importantly, on a personal level for the individual practitioner.

Moving the Plan off the page - Pilot Stage Approaches

Key to the pilot programme's success has been the active involvement of health and care professionals, voluntary sector, trade, the public, subject matter experts, service directors and leaders. It's critical we engage, inspire and motivate those at the sharp end of care delivery so they feel empowered to change things for the better for the patients they serve.



The Ten Point Plan Service Improvement Framework for Nutrition

An outline of the Ten Point Plan framework is outlined below;

TEN STEPS TO A COMMISSIONED CARE PATHWAY (THE TEN POINT PLAN)	
THE GOAL IS TO CREATE A MULTI-ORGANISATIONAL, PAN SECTOR COMPREHENSIVE CARE PATHWAY RECOGNISED AND APPLIED BY ALL	
• Acute, community, social, 3rd sector and industry • Potentially split up / delivered by disease area	• Endorsed by key stakeholders • Piloted in one or more CCGs
1. **Understanding the challenge through case reviews** • Spotlight failures and breakdown of care at the interface	**6. Change point of care** • Don't rely on one point of entry to system • Joint reviews dieticians and community pharmacists • Include voluntary sector and unpaid carer • Don't neglect GP's either
2. Create regional and sector champions • Clinical and operational	**7. Reset the workforce** • Role of the prescribing dietician in the MDT - and pharmacists • Elevate role of voluntary sector as prompters • Opportunity to educate / retrain
3. Involve the sectors • Industry, NHS, HCPs, third sector • Opportunity to cost pathways (e.g. opportunity cost, avoidable cost of management in own home v hospital) • Opportunity to run pathways (e,g B2B industry/care homes) • New products • Risk shares and LAP (lead accountable provider) • Voluntary sector and the 'befriender and carer' • Incentives - evaluating products in a different way? • Keep specialist expertise	**8. Minimum standards required** • Ensure NICE CG32 and QS24 are recognised and implemented • Ensure MUST and malnutrition pathway is followed • Mandate ONS in certain situations • Create specific time-lines and milestones for patient monitoring and review • Create risk profiling guidance / set of common sense indicators
4. Grasp the key challenges • Prioritise main disease areas • Apply financial targets	**9. Sanctions** • Targets to encourage compliance • Sanctions for non compliance
5. Increase awareness • Mandate nutritional health check • Screening on admission (and?) • Signposting to key groups (e.g. dieticians, pharmacists)	**10. Pilot the new pathway in one or more CCGs**

Summary of the 10 Point Plan Service Improvement Framework and its associated service benefits

Area	Key benefits of implementing the 10 Point Plan
1. Understand the level of opportunity through pathway reviews.	Encourages evidence action-based learning and service development which is more credible to clinicians and practitioners. By focusing on the patient pathway and "walking in a patient's shoes" it generates valuable insight. Encourages a focus on the cost of inaction and the clinical, social and operational costs associated with doing nothing. Such an approach will increase the profile of malnutrition and hydration and the status of the professional groups managing it.
2. Create regional and sector champions.	Provides clear leadership and guidance for the whole system. Will increase professional and clinical accountability. Delivering across a region creates scale and credibility and will lead to a higher value return on investment.
3. Involving the sectors.	Through ensuring all sectors are involved, it enables the development of a truly integrated system-wide pathway and solution. This will ensure that patients receive the best care from the relevant expertise in the best location for them. Demonstrates that malnutrition and dehydration require a more comprehensive pan-system approach, rather than one which is focused on individual organisations. Demonstrates in practical terms how dietitians can play a key role in integrated health and social care teams and add real value. Demonstrates the potential value added by the voluntary sector and the critical role of the family, and the role of relatives as carer/s.
4. Grasp the key challenges.	Demonstrates the value of using the evidence to target the intervention. Suggests a stronger focus on the disease-based causes of malnutrition and dehydration such as COPD, dementia and frailty. Evidences the significant clinical risk and levels of complexity being managed by the residential and care sector. Highlights the importance of regular screening for malnutrition and dehydration for patients over the age of 65, and how it can be done more efficiently within existing resources and capacity.
5. Increase awareness.	Suggests that screening should be mandated on admission and discharge. Recognises the value of medicines utilisation reviews, elderly care assessments and health checks, and provides guidance and examples of how these can be enhanced to incorporate screening for malnutrition and dehydration and dietetic support in these areas. Suggests that increasing awareness of malnutrition and dehydration should be mainstreamed and mandated through staff inductions. More comprehensive training ensures that all practitioners working in integrated health care can screen and manage /monitor post diagnosis.
6. Change point of care	Provides model pathway resources which will help to simplify patient management and care. Provides examples of how dietitians can be aligned with integrated care teams. Demonstrates how community pharmacists can be enabled to provide care for malnourished and dehydrated patients on a wider scale.
7. Reset the workforce	Encourages and demonstrates the value of a system-wide /ICS approach to the education, recruitment and retention of dietitians. Suggests that health and care providers should standardise nutrition and hydration awareness and training in staff inductions. Provides practical examples on how to both maximise the expertise of dietitians and upskill the rest of the multi-disciplinary team in addressing malnutrition and dehydration, through the integration of dietitians into community teams and the wider operational business. Encourages health systems to maximise the skills and expertise of prescribing dietitians by increasing the amount of direct contact with patients and assessments undertaken. Many prescribing dietitians report that they spend too much of their time writing policy rather than supporting front line care. Demonstrates how best to equip and upskill the patient, carer and voluntary sector in order to widen the support network in this area (befriending and food prompting being two such examples).

Area	Key benefits of implementing the 10 Point Plan
8. **Minimum standards required and need to be implemented**	The 10 Point Plan calls for greater accountability across all parts of the system in relation to the implementation of NICE CG32. Calls for a review of the application of 'MUST' and the associated guidance. There is a need to ensure the guidance is more reflective of the underlying condition and sufficiently flexible to react to complexity and levels of frailty. Develops a clear consistent pathway for the appropriate use of ONS in community and primary care settings. ONS should be recognised as part of a clinical care plan as referenced in the Managing Adult Malnutrition in the Community Pathway.
9. **Contractual levers**	Recommends a national CQUIN to encourage regular screening and ultimately prevention for malnutrition and dehydration across acute and community providers. Calls for a new dialogue with CQC in relation to the assessment of how healthcare organisations provide for a patients nutritional needs
10. **Launch in more CCGs/STPs/ICSs nationally**	Action based learning of this sort has generated significant value and demonstrates that, with the right intention and focus, significant change can be delivered in a relatively short period of time.

The Case for Change

Treating Malnutrition at source to avoid crisis

This report seeks to demonstrate that we can minimise crisis in our elderly population by actively treating and managing malnutrition. It also calls for dietitians to be given the status, profile and professional flexibility within local integrated care teams to make a real difference.

Focus on the practical.

There is no magic solution but there are practical steps that can be taken to ensure the impact of malnutrition is recognised, understood and managed, which would provide significant benefit for patients, their relatives and the healthcare profession.

There is no doubt that if we do not make nutrition and hydration everyone's business and give dietitians the professional flexibility and platform on which to perform their crucial clinical role, we will continue to miss a real opportunity.

Andrew Lane Chairman of the National Pharmacy Association

The estimated cost to the public purse of malnutrition is £19.6 billion.

Improving Identification and treatment of malnutrition is estimated to have the 3rd biggest potential to delivery cost savings and improve outcomes.

The 10 Point Plan provides CCGs/STPs/ICSs with a practical toolkit for improvement developed by professionals for patients.

There have been numerous efforts to address nutrition and hydration challenges through policy and service development. However, this has not always translated into the necessary service change on the ground or resonated with the practitioner on the operational front-line.

The 10 Point Plan was conceived to address these issues. Its goal was to create a multi-organisational; pan-sector comprehensive care pathway recognised and applied by the acute, community, social, third sectors and industry. It is hoped that, if successful, the plan will be endorsed by key stakeholders and rolled out in CCGs/STPs/ICSs nationally.

Dietitians have a key role to play and they need to be embraced. The role of dietitians is often poorly understood by commissioners and means that dietetics has become an easy target for funding cuts and de-prioritisation.

Each area should be mandated to look at its referral policies to dietetic services and ensure that there is a consistent set of referral guidelines in place. This will help to ensure that specialist expertise is protected and maximised.

Dietitians must be part of the solution.

Dietitians are key to unlocking a range of health and social benefits for the patient and, with it, associated savings for the health and care system.

In all pilot areas dietitians were recognised as a scarce resource often working in isolation to the wider health and social care teams. As such it was felt that greater emphasis needs to be placed on:

- Integrating dietitians as part of the core primary community care and social care teams. This is a key opportunity.
- Expanding the core skills of the community healthcare teams in this area as well as newly established Primary Care Networks (PCNs).
- Developing robust triage programmes that are more reflective of the clinical and social needs of the patient, ensuring that limited dietetic resource is prioritised for those patients who require it the most
- Recognising the positive contribution dietitians make to service change, innovation and enhancing patient care. For example, in Kent dietitians identified elderly patients at risk of social isolation and referred them to befriending and other support services.
- Recognising that dietitians are not always enabled to work to the "top of their professional license and competencies".
- Ensuring caseloads are not disproportionate to commissioned activity levels and are at sustainable levels.
- Highlighting the role of dietitians as being often poorly understood by commissioners, meaning that dietetics can become an easy target for funding cuts and de-prioritisation.

“ It costs more not to treat malnutrition than to do so and it is estimated that £5,000 could be saved per patient per annum through better nutritional management and care. ”

Forgotten not Fixed – a blueprint to tackle the increasing burden of malnutrition in England. BSNA 2018

The estimated cost to the public purse of malnutrition is £19.6 billion.

The 10 Point Plan pilot programme has evidenced that not assessing hydration and nutrition needs on admission leads to a longer length of stay, as patients are not able to mobilise as easily and are generally less medically fit.

The difference in length of stay between the two patient pathway examples examined was 6.6 days, and the difference in cost was £3,560. Therefore, for every ten elderly care short stay admissions where the risk of malnutrition and dehydration is identified earlier and managed appropriately, the health economy could save around £35,600 and 66 bed days.

We believe that delivery of the recommendations from the 10 Point Plan pilot programme will generate at least a 10% improvement in cost efficiency through earlier detection and proactive clinical management of malnutrition. If each of the three pilot sites followed NICE CG32 guidelines they could generate the following savings which are based on the number of avoidable hospital admissions due to malnutrition.

NHS and Social Care in Crisis

The challenge is real. The NHS must save £20 billion over the next 5 years to get the health system back to financial balance, this will require CCGs and NHS Providers to have robust annual saving and cost reduction plans in place.

The slow dismantling of adult social care in many parts of the country means that these services are now at breaking point. A projected funding gap of approximately £2.5 billion in 2019/20 will lead to more cuts, decommissioning and a significant impact on frontline services with demographic growth under provided for. Funding of public services has shifted from an average 3% annual increase in 2016/17, to a 0.75% increase in 2018/19, to approximately 1.5% in 2020/21. When compared against the standard annual increased cost of treating patients over the age of 65 of approximately 3.9%, the comparative lack of funding will generate significant fiscal pressures across the NHS and social care. (Autumn Budget 2017, what it means for Health and Social Care. Kings Fund).

The graph below (Fig.1) demonstrates the upward trend in the number of residents over the age of 65 in Wiltshire (one of the pilot areas), and a significant increase in the number of people over the age of 85 years. Wiltshire health and social services will need to identify almost an additional £60 million by 2021 to manage the additional demand pressure caused by this level of demographic growth. (Better Care Plan 2014, Wiltshire Council and Wiltshire CCG).

	Estimated savings	Potential number of admissions avoided per annum
Wiltshire	£382,008	600
Kent	£1,211,849	850
Essex	£1,467,276	1000

Source: NICE Guideline, CG32 Costing Template

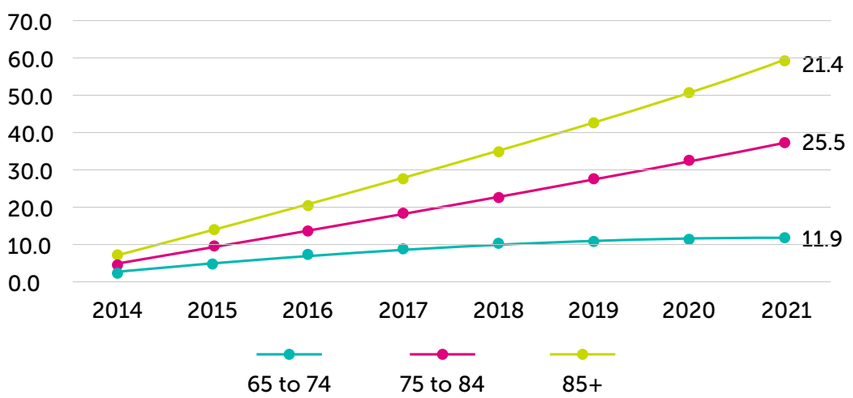


Fig.1

Cumulative increase in annual resource requirements (£m) by 10 year age band in >65s updated 2014/15 baseline average spend per head = £58.8m

Patient Pathway Reviews

“Walking in the patients’ shoes ”

The typical patient is complex and at the point of crisis.

A typical patient evaluated through the 10-point plan programme had the following characteristics:

- Age 85 +
- 3 or more long term conditions
- Socially isolated (lives alone) and/or in long term care
- High level of frailty
- Three or more hospital emergency admissions in the last 12 months
- At risk of future admission to hospital

Moving away from performance and the numbers, what we are seeing is essentially a missed opportunity to tackle malnutrition and the causes of malnutrition at source. Much more needs to be done to provide high quality care at the point of need, transitioning more patients towards full independence and ensuring a greater focus on prevention and enhancing wellness. Comprehensive nutritional care for elderly patients is critical in ensuring transition to wellness and independence. *ALTHOUGH THIS IS AN ALL AGE PROBLEM – JEREMY DATA*

Understanding the wider impact on the patient

It is also recognised that malnutrition and dehydration will impact on healthy tissue viability and ultimately have implications for pressure ulcer recovery. Holistic assessment on admission is critical in reducing the risk of pressure ulcers. As the data below demonstrates we have seen an increase in the incidence of pressure ulcers. It is estimated that between 4 – 6% of patients in the acute care setting suffer from pressure ulcers. It is estimated that between 4.5 – 10% of patients in the non-acute setting suffer from pressure ulcers.

Between 2001 to 2012 pressure ulcers (Decubitus ulcers) were mention as an underling cause of death in 2772 cases and a contributing factor to death in 11599 cases in England and Wales.

It is estimated that between 80 – 95% of pressure ulcers are avoidable.

Treatment cost ranges from £1,064 (grade 1) per patient to £10,551 (grade 4) per patient with a daily cost ranging from £43 to £374.

Hospital acquired pressure ulcers increase the length of stay by an average of 5-6 days per pressure ulcer.

The total cost to the NHS is between £1.4 billion and £2.1 billion or 4% of the annual NHS budget. The opinion of the NICE Guideline Development Group is that this is a conservative estimate but evidence for this opinion was not given.

The human cost is a reduced quality of life for the patient, their carers and their families. Often patients who develop pressure ulcers require prolonged and frequent contact with the healthcare system and suffer much pain. They also create a number of significant difficulties psychologically, physically and clinically to the patients. It may also lead to sepsis and death.

Savings may be possible by implementing best practice and reducing the number of people who develop pressure ulcers.

Pressure ulcers are preventable and cause a substantial increase in health care resources. Prevention can be achieved by assessment and monitoring of patients and by education of both HCPs/carers and patients. (see appendix 8 for references).

Pressure ulcers are an unintended consequence of malnutrition and dehydration, which are preventable and cause a substantial increase in health care resources.

Social Isolation

Whereas once family members were the major care givers for older persons, this is no longer the case, as families have become more dispersed.

There is a very clear role for the voluntary sector in this regard and one should not underestimate the value of the conversation and the positive impact that face to face communication and support like food prompting has in relation to elderly people returning to a regular eating pattern.

Quality must be primary consideration

A cost/savings first focus has led to a number of commissioners promoting a Food First Fortification (FFF) approach which is not always in the best interests of the individual patient at that point in time.

There is at least a 40% decline in function at the point of discharge for malnourished patients with COPD (as seen by the Community COPD Team in Mid Essex) and in this instance a more balanced approach incorporating both FFF and appropriate use of ONS would be required.

A more holistic assessment of a patient's dietary needs, personal preferences and level of tolerance is required. Some possible solutions in this area include mandating the nutritional health check assessment and developing joint clinical pathways for the appropriate use of ONS to get patients back to function and recovery.

MUST and its application should be reviewed nationally and aligned with local risk profiling and tools like the frailty index

Nursing and residential homes are unable to make direct referrals to dietetic services, there is also a need to standardise and simplify referral pathways.

GPs in the pilot areas have fed back that ONS plays a valuable part in reducing the impact of clinical malnutrition and there is a need for clearer clinical pathway for appropriate prescribing of ONS in primary and community care settings.

There is a concern that use of the Malnutrition Universal Screening Tool ('MUST') in isolation will not ensure the effective clinical management of complex patients with malnutrition.

Feedback by clinicians in the Pilot Sites, identified that the assessment ranges do not always reflect the clinical complexities associated with frail elderly patients and often generate the wrong type of outcome.

'MUST' is a five- step screening tool to identify adults who are malnourished (undernutrition) or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.

The 10 Point Plan Report recommends that 'MUST' should be used in combination with clinical judgement especially with more complex patients including the frail elderly. Based on feedback from the pilot sites, clinicians should view 'MUST' as a valuable part of their assessment toolbox.

Malnutrition increases dependency which in turn generates the poor clinical outcomes and more cost:

The malnourished group reviewed during the programme:

- Saw their GP 2.1 times more often than the well-nourished.
- Had three times the number of hospital admissions.
- Stayed in hospital more than 3 days longer.
- Lived with more co-morbidities.

Managing crisis within the first 72 hours and tackling nutrition and hydration at source.

It is clear that there is not always enough multi-disciplinary team capacity in the community to proactively manage crisis at the point it occurs.

Education is key: it is important that time is given to educating front line staff about the benefits of using assessment tools appropriately so that patients and professionals can derive the most benefit from them.

This report recommends that 'MUST' and its application is reviewed nationally and aligned with local risk profiling and tools such as the Frailty Index used in primary care, so that clinical and social intervention following assessment

is targeted appropriately. 'MUST' is not a tool to be used to make commissioning decisions. In Kent the 'MUST' assessment process was incorporated into the electronic patient administration system as a first point of triage and assessment.

It is critical that we use 'MUST' appropriately and enhance its clinical and operational relevance, revised guidance and an implementation framework should be provided to all health and care systems. 'MUST' should be used as the starting point of assessment and triage and then as a guide to ensure appropriate timely referral to dietitians or other Healthcare professionals.

Impact of screening and comprehensive case management.

In understanding the potential positive financial impact that effective management of malnutrition will generate, we looked at the impact on a frail elderly patient's length of stay in a hospital and compared pathway impact. We reviewed 20 patient pathways (frail elderly admissions to hospital) and considered in detail the different impacts of effective care and sub optimal care.

In reviewing the patient journeys, we looked at a typical point of entry into a hospital which included emergency admission through Accident and Emergency (A&E), followed by an inpatient stay on a ward (NE) and then an outpatient follow up appointment (OPA).

The typical pathways are demonstrated in the table below

Pathway Shape						ALOS	Pathway Average Cost
4.1	3.0	AAE		NE	OPA	4.1	£2,722
10.7	4.0	AAE	NE	NE	OPA	10.7	£6,282

Fig. 2

Typical pathway shape and differences in pathway length with proactive management of malnutrition and dehydration compared with the alternative

In general, patients with a shorter length of stay in hospital (and consequently a lower unit cost) were:

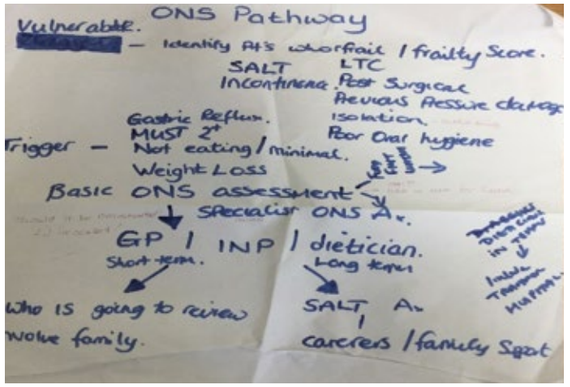
- Screened on admission to the ward.
- Had been assessed by a dietitian.
- Were diagnosed as being medically malnourished and were appropriately prescribed ONS or supported with food first fortification where applicable.
- Were weighed daily.
- Were discharged as soon as they were medically fit.

The lessons from these patient pathway reviews in the pilot sites were critical in helping us to define and create the ideal patient pathway for the management of malnutrition and demonstrate that lower quality care is ultimately more expensive.
The savings that can be delivered through the 10 Point Plan present a significant national opportunity. The areas in bold below align with the key service changes recommended by the 10 Point Plan pilot programme:

Better screening earlier in the pathway which prevents malnutrition or the malnourished state exacerbating – screening in Primary Care is the solution.

- Screening at admission and discharge into and out of all bedded environments – This needs to be mandated. A simple step would be recording weight of patients on admission and discharge
- Reducing length of stay through effective care planning and information sharing –discharging medically stable patients earlier into the locality based integrated teams will mean nutritional needs are managed more proactively and comprehensively in a home or community environment.
- Appropriately providing ONS in the community as part of a managed care pathway

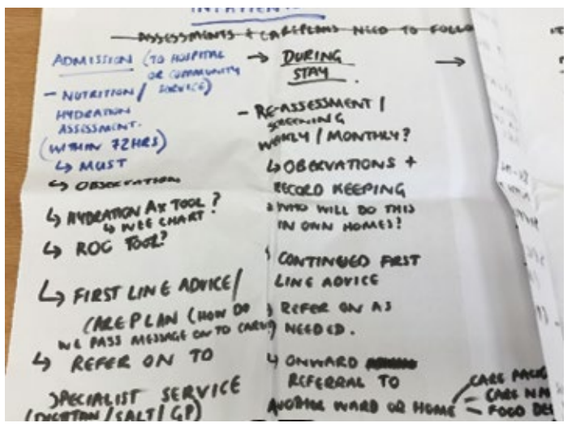
Practical Profession led solutions



Solution 1. Utilising the existing pathway in primary care and community settings.

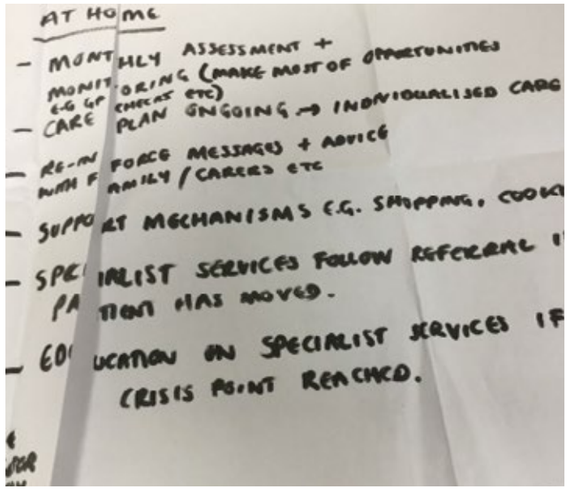
There is a significant opportunity to drive the appropriate prescribing of ONS (sip feeds) as part of a clinical pathway. "Managing Adult Malnutrition in the Community" is a practical guide and pathway to assist community healthcare professionals in identifying and managing the 3 million people in the UK at risk of disease-related malnutrition. It has been developed by a multi-professional team and is endorsed by ten key organisations.

The (GP) Clinical Pharmacist role could also be utilised to review patient's medication given the impact certain medications have on appetite and hydration and consider the benefit of products such as ONS (SIP feeds). Given the increased focus on medicines optimization there is a perfect opportunity to ensure the appropriate prescribing of products in line with the need of the malnourished patient at that point in time.



Solution 2. Ensuring nutrition and hydration assessment form a core part of the inpatient pathway (as above).

Ongoing assessment doesn't have to be complicated, one such example is to ensure every patient's BMI is assessed on admission as standard. This could then form part of the 'MUST' assessment.



Solution 3. Providing comprehensive nutritional and hydration support for patients in their home.

Within their own home, patients themselves should be encouraged to take more responsibility for managing their own condition. Increasing awareness through education and information should not be exclusive to professionals and this report considers ways in which we can support the patient and the carer to identify the risk of malnutrition and dehydration and take steps to manage it.

In the Essex Pilot site, a large GP practice worked in partnership with the Patients Association to launch their Nutrition Checklist in Primary Care Settings. This report endorses the Checklist and suggests that it is rolled out to GP Practices nationally. GPs could use the questionnaire to screen all elderly patients as part of the annual GP health check for patients over the age of 75.

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The Patients Association Nutrition Checklist will be adopted across several care settings after the formal national launch in November 2019.

Care Homes: Key Findings from Consultation and Review

In the pilot areas, we engaged directly with a number of large nursing and residential homes and identified the following:

Complexity is significant

Commissioners and policy makers should give more consideration to nursing home residents particularly in relation to their age, co-morbidities, complex care needs and the amount of input required to return an elderly person back a level of independence. A number of patients are discharged from hospital with a level of dependency and clinical need which far outweighs the support that care homes can provide, e.g. the increase in the number of care home residents who are fed through a PEG Tube.

Greater emphasis needs to be placed on the clinical consequences of insufficient nutritional support and input

It is important to review end of life pathways, patients with end stage dementia and COPD, and consider both how needs are assessed, and care provided. We found evidence of rapid deterioration and weight loss in patients; for example, those with dementia and those with pressures sores as a result of malnutrition and dehydration. This was a consistent theme identified through the patient pathway reviews.

The 'MUST' screening tool could be applied more effectively in nursing and residential settings

'MUST' adds value where it is used appropriately, it is not intended to be used in isolation of professional judgment. In nursing and residential settings, it is critical that health and care professionals regard 'MUST' as a screening tool, forming part of a comprehensive care pathway solution for frail elderly patients rather than a solution in isolation. We suggest that this will be achieved if the comprehensive care pathway for the frail elderly is followed, that dietitians form part of the proposed Integrated Care Teams that are being established in community settings nationally, and that ongoing education and training is provided to the Care Home sector.

Acute hospital discharge processes

This area needs further review and analysis, as the focus is too heavily weighted towards fast transfer and releasing bed capacity.

Hospital discharge summaries are often incomplete and do not provide the clinical and social assessment information required to ensure targeted intervention and proactive case management in this area. Significant risk is being shifted to this sector, which needs to be recognised by the Care Quality Commission (CQC) when it undertakes assessments and reviews of hospitals, community services, nursing and residential care and GP Practices.

A Comprehensive Care Pathway for the Management of Malnutrition

One of the key outcomes from the 10 Point Plan Process was to develop an example comprehensive care pathway for the management of malnutrition. This pathway could be utilized across Integrated Care Systems or could be utilised across Primary Care Networks

Focused interventions along the patient journey.
The ideal patient pathway for the frail elderly managing malnutrition and dehydration.

Identified Focus Areas (Demographic)	Self-Care Prevention Presentation and Signposting	Proactive Treatment and Support	Supporting Patients at Home
Frail Elderly Patients	• Health Coaching and patient education. • Patient support information and effective signposting and navigation (such as the perfect patient information journey). • Mandate. • Sector specific risk stratification models to underpin stage prevention and self management. • Annual Nutrition and hydration screening for all patients over 75 in primary care settings. • Social prescribing. • Proactive patient and carer support through areas such as food prompting. • Dietician led triage in primary care. • Community pharmacy led assessment and screening.	• Dieticians at the heart of the integrated community structure. • Clear referral pathways to access community dieticians at the point of need. • Enabling community dieticians to provide more holistic care in the community. • Developing the wider MDT approach i.e. through use of dieticians, carers and the voluntary sector. • Launching the ONS pathway for community and primary care. • Appropriate application of MUST for complex conditions such as COPD and end of life.	• Nutrition and hydration screening within 72 hours of discharge home. • Agreed discharge pathway from hospital. • Carer support, education and advice. • Use of Patients Association screening questionnaire in 111 OOH triage. • On-going training and education programmes for Care Homes and domiciliary care providers. • All vital signs and clinical information in one place for assessment purposes. • Individualised care plans and monthly assessments.

The following table summarises each key stage of the suggested comprehensive care pathway.

The Typical Patient	Areas of Focus
Section 1 – Prevention	
Self-care and health coaching	Provide better information to the elderly and their carers in relation to managing the risk of malnutrition and dehydration (e.g. the proposed patient information pathway).
Patient information and signposting	Ensure that regular screening of risk is undertaken at the earliest point in the pathway in a way that supports the patient, their carer/s and professionals to identify and manage the risk of malnutrition and dehydration.

Section 5: The following table summarises each key stage of the suggested comprehensive care pathway

The Typical Patient	Areas of Focus
Undertake more screening and assessment in primary care	Utilise the high street presence of the community pharmacist to become a trusted source of advice, support and information.
	Screening to be undertaken annually as part of the elderly care health checks already commissioned and undertaken in GP practices.
	Fixed pathway points such as medicines utilisation reviews, health checks and flu jabs should be used as an opportunity to undertake screening.
Dietitian led triage	The pilot sites have highlighted an opportunity for dietitians to align with general practice through the elderly care health check. This will help to target intervention and provide more support to patients at the earliest point.
QOF and CQUIN	There is a need to align the incentives and levers in this area. QOFs (or equivalent) and CQUINs should be mandated for screening and assessment at all points of the pathway.

Section 2 – Proactive Treatment and Support	
High intensity care	It is critical that dietitians are given equal status as part of integrated health and social care teams in the community. Examples are provided on how this can be achieved.
Direct referrals	The pilot programme has developed clear referral pathways and has out-lined the need to expand direct referrals routes to areas such as nursing and residential care, 111/OOH teams, domiciliary care and community nursing.
Increasing the ambition of intervention	Low level interventions should also be prioritised in areas such as: – Self-screening and assessment. – Using the voluntary sector in areas such as food prompting and targeted visits. – Extending social prescribing. Upskilling a wider range of clinical and care staff and making malnutrition and dehydration everyone's business.

The Typical Patient	Areas of Focus
Extending to a wider MDT approach	In addition to the integrated team approach, the dietitian should be better aligned to specialist teams, particularly given the multi-morbidity impact of malnutrition. Areas identified as part of the 10 Point Plan programme include: – Dietitians working with palliative care teams (developing a more bespoke assessment programme for patients on an end of life pathway). – Dietitians supporting community geriatricians in their work in the community (one area would be reviews of patients in nursing and residential homes).
Section 3 – Supporting Patients and Home	
Domiciliary care	Defined role for domiciliary care staff. Supporting the unpaid carer through extension of social prescribing, providing with the right information at the right time and helping them to identify the key risk factors.
Improving information exchange	The quality of information exchange at discharge from hospital and transfer between core services should be improved through: – Standardising referral pathways. – Developing online referral forms on existing systems. – Requesting that a minimum data set is applied to discharge summaries. – Identifying in relation to ONS information what needs to be provided to ensure the most appropriate prescribing decision is made. – Developing the perfect patient information journey.

Section 5: The following table summarises each key stage of the suggested comprehensive care pathway

The Typical Patient	Areas of Focus
Section 4 – Legacy.	
Elevating the role of the dietitian	The senior dietitian should be at the heart of newly developed integrated health and social care teams. Examples of this from both Essex and Kent are available in the report. Nutrition and hydration steering groups should be established for each of the ICS areas.
National Training Programme	A national training and education strategy should be developed.
	All health and care staff should receive training on detecting and managing malnutrition and dehydration as part of their induction. This was evidenced with success in the Kent pilot, in which staff induction processes for front line clinical practitioners have been updated to increase awareness on how to identify and manage malnutrition and dehydration.
Enhancing the role of the voluntary sector	There needs to be a stronger focus on befriending, food prompting and social prescribing. The Patient Association questionnaire at Appendix 3, used in the Essex pilot, provides an opportunity for the voluntary sector to redefine their purpose through the scaling up of detection, assessment and signposting.

Key Recommendations

Leadership

1 Set up a Clinical Standards Board for the management of Malnutrition in each Integrated Care System (ICS) and ensure linkage with the developing Primary Care Networks (PCN).

2 Empower each Clinical Standards Board to develop, implement and oversee a core dietetic service offer and implementation of a system wide clinical pathway.

3 Appoint a National Clinical Lead for Nutrition and Hydration working across health and social care. This should be underpinned regionally by senior dietitian representation on ICS/STP Clinical Forums.

Assurance

4 Ensure systems are measuring "what matters" through the recommended key performance indicators for systems to measure and monitor.

5 All systems should be encouraged to implement the Malnutrition Universal Screening Tool ('MUST') at key points of the patient pathway and evidence this is the case.

6 Develop a National CQUIN Framework to incentivise monitoring and management of malnutrition.

7 That CQC, undertake more direct reviews of the impact of malnutrition and dehydration on patients Teams established with a power to 'drop-in' on hotspots of poor nutrition and hydration. This should form a key part of the new system review processes the CQC are putting in place.

8 Take urgent practical steps in relation to the implementation of NICE guidance with a view that NICE Clinical Guideline 32 on Nutrition Support in Adults should be made mandatory and assessed accordingly.

9 Undertake a mandatory national annual audit on number of dietitians in post and caseload per dietitian. This neatly aligns with the recent work being progressed by BAPEN.

10 A specific inspectorate for nutrition and hydration should be formed and operate across primary, secondary and community care.

Innovation and Service Improvement

11 Develop a national training programme to underpin mandatory training, ensuring that all staff have the knowledge and expertise to correctly diagnose and signpost patients with malnutrition and dehydration.

12 Focus on primary prevention by encouraging GP Practices to screen for malnutrition at each annual health check for patients over the age of 75.

13 Ensure that all integrated health and social care teams being developed across the NHS have a senior dietitian at their core and as a key member of the multi–disciplinary team ensuring that dietitians are being used to their full potential.

14 Implement the comprehensive care pathway for management of malnutrition in CCGs/STPs/ICS and PCNs.

Steps to success

Small steps that could make a big difference in improving the care and treatment the malnourished and dehydrated patient receives:

1. Respect and recognise the value in preventing malnutrition and dehydration and invest in it.
2. Dietitians must be part of the solution, which comprises integrated community teams and local team approaches.
3. Recognise a service user's independence as key.
4. Move away from the numbers game and focus on outcomes. This requires a focus on maximising assets, generating a return from each intervention, supporting staff to work at the top of license and integrating responses.
5. Providing excellent nutrition and hydration care is everyone's business, which must be signified in staff training, team development, professional standards and accountability. Emphasis must be on increasing awareness of all Healthcare Professionals.
6. The patient must be encouraged to take responsibility through a personalised care planning approach.
7. Simple behaviour change makes a big difference. This applies to systems, organisations, teams and individuals, professionals and patients.
8. Need to be bold in the way services collaborate and innovate The NHS and Care Providers should look to engage the industry as partners in this agenda.
9. Protect the specialist expertise. Through clear referral pathways, consistent standards and better service coordination, we can free up dietitians to make more of an impact on a bigger number of patients.

Suggested Key Performance Indicators

Measuring what matters

Setting the Standard through the Development of Ambitious Key Performance Indicators and Targets.

Several key performance indicators (KPIs) were developed during the 10 Point Plan pilot programme. We suggest that these are adopted by health systems to ensure that not only are they measuring what matters but they gain a thorough understanding of the care offered to elderly patients in this area.

KPIs will help to provide a more granular understanding of the care patients are receiving and to ensure that healthcare providers are held to account through consistent measurement and evaluation. The KPIs we propose seek to serve as a guide for policy makers. These could be piloted in the first year for data collection purposes and then rolled out nationally. They could also link to any new CQUINs.

The following key performance indicators were developed during the national 10 Point Plan programme, it is suggested that these are adopted by health systems to ensure that not only are they measuring what matters but gain a thorough understanding of the care offered to elderly patients in this area. A key recommendation of the report is to support systems to "measure what matters" through the launch of recommended key performance indicators for systems to measure and monitor the progress being made in managing malnutrition more effectively.

Primary Care Assessment

- % of patients diagnosed with malnutrition and dehydration that have an active care plan in place.
- % of patients over the age of 75 who are receiving their annual screening for nutrition and hydration.

Acute and community Care

- % of patients screened on admission in acute settings (must be collected and published).
- Number of patients diagnosed with malnutrition and dehydration in acute settings.
- % of patients over the age of 75 discharged into home or community settings who are screened within 72 hours of discharge.

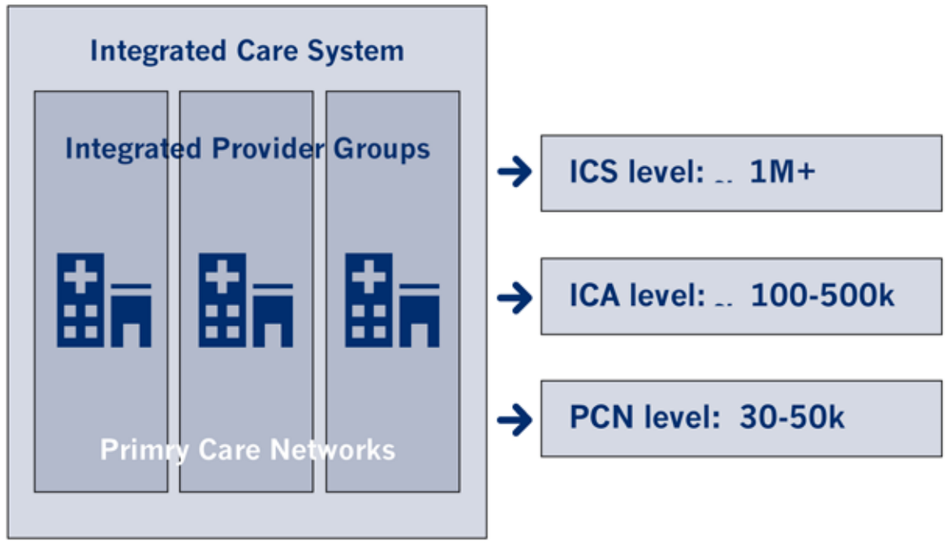
On-going management and response times:

- All community teams compelled to publish average waiting times for access to dietetic services.
- % of elderly patients who see a dietitian within 10 days of urgent referral.

Opportunities associated with the NHS Long Term Plan

Opportunities to Increase the relevance and impact of good nutritional care across a Changing NHS.

Structural change in the NHS.



The NHS Long Term Plan states that ICSs work by creating joined-up, patient-centred care at broadly three levels:

Primary Care Networks (c.30-50k populations) at a minimum, PCNs collaborate to deliver extended access and sharing functions or workforce to reduce day-to-day pressures which will typically align with local government units, should be the engine room of resource planning, and care redesign and population health management for local communities. Most ICS say that about 80% or more of their work is organised around the place or neighbourhood level.

Integrated Care Alliance (Place based 100,000 to 500,000 populations, sometimes known as Borough based partnerships) which will typically align with local government units, should be the engine room of resource planning, care redesign and population health management for local communities. Most ICSs say that about 80% or more of their work is organised around "place" or "neighbourhood" level.

Integrated Care Systems (c.1m+ populations) these discharge responsibilities at a scale larger than Integrated Care Alliances. These include workforce, capital and estates planning, digital, specialised services and reconfiguring the acute care landscape. They will oversee a single operating plan and system control total that encompasses CCGs and NHS providers. Systems are increasingly taking responsibility for financial and operational performance across the whole system, supported by new governance arrangements.

Delivering the NHS Long Term Plan - Changing the point of intervention

"Getting a seat at the table" Increasing the profile of the profession.

This report suggests that as a minimum for each Integrated Care System there should be a defined Clinical Director for Malnutrition and Hydration with responsibility and reporting accountability to the ICS Board, and at each Integrated Care Alliance there should be a Lead Senior Dietician identified to be part of the Clinical Leadership team of the Integrated Care Alliance alongside other lead Allied Health Professionals.

Integrated Care Alliance - Service Example from Essex:

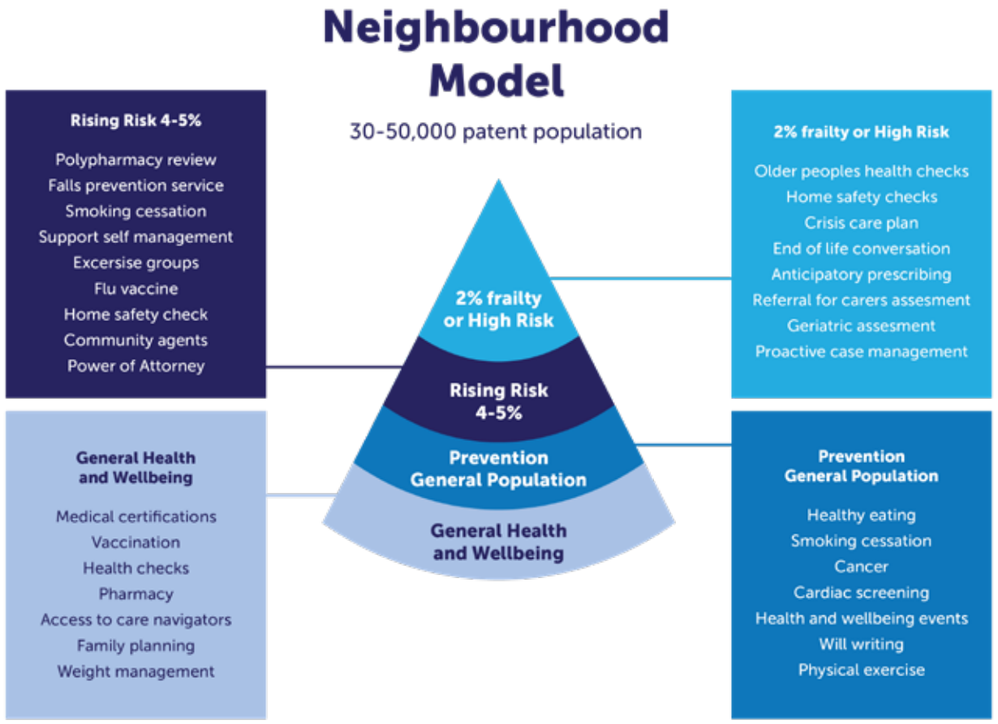
As part of implementing the key recommendations from the 10 Point Plan, West Essex Integrated Care Alliance will have a nominated lead dietitian as part of the system Professional Leaders Group providing them with an opportunity to represent the profession and its agenda as well as playing a key role in the development of integrated clinical care pathways across the locality.

Integrated Care System Service Example from Kent "Standardising care and delivering best practice as one system".

Across Kent, a Hospital Geriatrician has been identified as the clinical lead responsible for malnutrition and working in partnership with dietitians and other Health Care Professionals the system is working towards:

- Developing a common system formulary for the use of ONS and other products.
- Embedding an annual training programme for health care staff and organisations to improve detection and ongoing management of patients with malnutrition
- Developing a core dietitian offer to Primary Care Networks.
- Annual audit of prescribing and delivery of guidelines (focus on appropriate)
- Annual review of compliance against NICE Guidance.
- Annual "snapshot "audit of malnutrition related admissions to hospital.

Influencing at the point of intervention – Developing a Core dietitian offer to Primary Care Networks



In line with the typical Primary Care Network model outlined above, the 10 Point Plan recommends that dietitians should be given a core role at the heart of integrated community care teams and the emerging Primary Care Networks. As demonstrated in each of the pilot sites, dietitians can provide impact in several ways and help to ensure delivery of the key strategic objectives of the NHS Long Term Plan on a local level. Dietitians can add value in the following ways:

- At the MDT table influencing clinical case management conversations.
- Signposting high risk and complex patients to appropriate services such as in South London, where dietitians signpost elderly patients to voluntary sector services.
- Case finding.
- Direct clinical care and support to patients identified as being malnourished or at risk of malnutrition.
- Working in partnership with other Health Care Professionals to develop appropriate care pathways for patients at risk of malnutrition.
- Increasing awareness of other Health Care Professionals across the Integrated Primary Care Network and Community Care Team so they can identify patients at risk of malnutrition, assess and put in place an appropriate care plan.

NHS Long Term Plan – Key Financial Messages

Appropriateness is the key message

Despite the overall efficiency of the NHS, there is still waste and an opportunity to improve efficiency. Up to 10% of hospital admissions in the elderly population are medicines-related, so pharmacists will routinely work in general practice helping to relieve pressure on GPs and supporting care homes. Research shows as many as 50% of patients do not take their medicines as intended and pharmacists will support patients to take their medicines to get the best from them, reduce waste and promote self-care.

Prevention of illness will also become a key priority as a way of reducing the pressures on the service.

Standardising medicines management policies across Integrated Care System will be a key driver for appropriateness and ultimately prevention of malnutrition.

Improving Identification and treatment of malnutrition is estimated to have the 3rd biggest potential to deliver cost savings and improve outcomes.

Reducing inappropriate demand and tackling the causes of malnutrition.

Effective medical management of malnutrition will make a significant contribution in reducing avoidable costs as it will ultimately prevent crisis in patient groups such as the frail elderly and prevent exacerbation of existing medical conditions.

Appropriate prescribing

As evidence from the 10 Point Plan pilot sites demonstrate appropriate use of ONS and delivery of Food First Approaches can have a real impact in terms of getting the patient back to baseline and preventing further illness.

Delivering the ambitions of the NHS Long Term Plan

Appropriate prescribing of ONS can improve patient outcomes and ultimately reduce NHS costs given that malnutrition occurs in many different disease states such as; cancer, COPD, CHD, dementia and stroke. As evidenced improving nutritional status can help enhance patient health, wellbeing and outcomes, whilst reducing NHS Costs associated with:

- Hospital admissions and readmissions
- Length of hospital stay (as evidenced in all 3 pilot areas)
- GP visits
- Increased use of healthcare resources in the community

Standardising approaches – GPs involved in the 10 Point Plan pilot areas commented on the ONS pathway for use in Primary Care and the Community and this is available as a resource from the programme.

Appropriate Prescribing is cost effective. Some CCGs have redesigned their Nutrition Service Pathway and have developed a clear system wide pathway for the appropriate use of ONS, this has generated savings of circa £500,000 per annum and provides an excellent framework for application across the NHS.

Monitoring quality, outcomes and appropriateness

Development of a National CQUIN for Management of Malnutrition

One of the key recommendations from the national 10 Point Plan process is to call for the development of a nationally mandated CQUIN which focuses on the management of malnutrition across acute, community and primary care settings.
Such an approach will be critical in raising the profile of the malnutrition agenda and hold health and care systems to account for demonstrating improvements in quality and innovation in the malnutrition pathway. In particular such an approach would ensure:

- Commissioners are clear on their intentions in this area.
- That nutrition care pathways are established to meet patients' needs wherever care is provided.
- That key outcomes relevant to malnutrition are in the contracting, quality assurance and performance monitoring of commissioned services.
- Ongoing evaluation and measurement of key indicators.

The National 10 Point Plan Process and associated service pilots have created a range of resources that could support the development of a national CQUIN such as a suggested care pathway, Key Performance Indicators, example service plans etc.

Action plan for Stakeholders

Bringing the 10 Point Plan Service Improvement Framework to Life

Stakeholder	Key actions
Central Government	– Appoint a Clinical Director for Nutrition and Hydration. – Engage with the dietetic sector and their respective professional groups about what support they need and how a joint, fit for purpose workforce can be developed for the future. Solutions are needed urgently given that workforce is the number one risk in the health and care sector
Regulators (NHS England and NHS Improvement)	– Ensure nutrition and hydration data and standards are positioned within the NHS Right Care agenda and within the disease areas identified. – Ensure there is clear accountability between commissioners and providers in this area and that existing levers are applied, and policy followed. – Mandate a national CQUIN for nutrition and enforce quality and care standards in this space. – Encourage CQC to develop an inspectorate for nutrition and hydration care across care settings and develop a more targeted inspection approach. Highlight need, and lobby for, more acute focus on nutrition within Local Authority performance frameworks. – Work with national bodies such as the BSNA, BAPEN and BDA to appoint a National Clinical Director for Malnutrition as well as Lead Dietician role.
Commissioners	– Patient pathway reviews and analysis alongside the patient voice need to be at the core of all commissioning decisions made and service decisions made. – Break down the unnecessary artificial barriers that exist between acute and community dietetics; seize the opportunity presented through NHS Long Term Plan and its removal of traditional boundaries between primary and community care, and commission services on a whole pathway/pan-system basis. – Implement the ideal patient pathway for frail elderly patients. – Launch and measure against the suggested Key Performance Indicators. – Ensure there is an identified clinical lead for the agenda in each locality.

Stakeholder	Key actions
Providers	– Mandatory and professional development training. – Ensure all clinical and operational staff, as part of their induction, receive training on the identification and management of malnutrition and dehydration. This should be part of a wider safeguarding issue. – Ensure there is an identified clinical lead in place. – Ensure all elderly patients are screened for malnutrition and dehydration on entry to and exit from core services.
The Patient	– Take real responsibility for self-care. There is no greater area of personal responsibility than eating and drinking, and patient and carers should be regularly encouraged to complete self-assessment questionnaires. – Encourage patients and carers to get more involved in co-designing and co-producing services and outcomes. – Take services to where patients present. Luncheon Clubs and "meals on wheels" for the elderly provide an excellent service and consideration should be given as to how these are supported by the appropriate care expertise to review patient's risk of malnutrition and dehydration.

The 10 Point Plan

Trusting professionals to develop solutions for their patients

"It's critical we engage, inspire and motivate those at the sharp end of care delivery so they feel empowered to change things for the better for the patients they serve."

Over the last 10 years a number of very valuable policy documents and guidance in this space have been developed, but they have unfortunately been left on the shelf, I believe the approach set by the 10 Point plan will endure. The key strength of the 10 Point plan is that it embraces the realities of service provision and is more likely to be embraced by the front line as it is been developed at "the coalface" of service delivery.

Dr Steven Lloyd

The 10 Point Plan was devised by James Roach, CEO of Conclusio Limited. James is an experienced NHS Director who has led Clinical Commissioning Groups, been a Joint Director of Health and Social Care and is currently leading the development of an Integrated Care System. James was provided with an unrestricted grant by the British Specialist Nutrition Association (BSNA), which covered the time and input of Conclusio Limited only and not the organisations involved in the pilot sites. The views reflected in this report are not necessarily those of BSNA or its members.

This report has been written by James Roach, incorporating and reflecting the views and recommendations of the participants in the 10 Point Plan pilot programme. It should be noted that the organisations gave their time for free and willingly and positively engaged in the pilots as they recognised the value of this approach not just within their own settings, but nationally. The author extends his sincere thanks to all those involved.

Conclusio Ltd
Inspiring Innovation

Organisations Engaged with

Provide Community Services Essex

Medway Community Service Kent

The Patients Association

Medvivo

Wiltshire Care Partnership

BSNA

Evolving communities – Wiltshire, Gloucester
Healthwatch Kent and Essex

National Pharmacy Association

Essex LPC

BAPEN

St Helena Hospice and
Dorothy House Hospice

The Patient Information Forum

The Patient Safety Collaborative

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