

WAKING GPs UP TO MALNUTRITION

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- GP representative on the 'Managing Adult Malnutrition in the Community' and 'Managing Malnutrition in COPD' consensus panels
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Why is detecting malnutrition so important?

- Malnutrition is widespread in the community
- At any point in time more than 3 million malnourished or at risk of malnutrition¹
- 93% of these live in the community¹
- Malnutrition affects:
 - 35% of people recently admitted to care homes² 29% of adults on admission to hospital³ 30% attending hospital outpatients⁴
 - 11% of people at GP practices⁵

Why is GP awareness so important

- Every day, over 1 million people will be cared for by their GP surgery⁶
- It is estimated that malnutrition costs over £90million per CCG^{7,8}



Barriers to GP diagnosis

Time – average 10 minute consultation



Barriers to GP diagnosis

Other priorities –
nutrition is usually
not high on the list



Barriers to GP diagnosis

Ownership - malnutrition cuts across traditional clinical specialty boundaries instead of falling neatly within one or other



Barriers to GP diagnosis

Weight loss is a red flag for underlying disease but it is less common for clinicians to recognise malnutrition as a modifiable entity that may influence disease outcome



Breaking down barriers/changing perceptions

- Need to raise awareness amongst GPs
 - breaking down myths of weight loss being a part of disease or ageing
 - need to make GPs think malnutrition when they are assessing patients particularly the elderly and those at high risk

1 in 10 older people*

are suffering from or are at risk of
malnutrition

 MALNUTRITION
TASK FORCE

www.smallappetite.org.uk

*over 65 in England and Wales (2009)

Breaking down barriers/changing perceptions

- Need to get GPs to identify screening opportunities:
 - GP registration
 - medication reviews (liaison with practice pharmacist)
 - at risk groups

Groups at risk of malnutrition include those with:

Chronic disease^{4,5} (consider acute episodes): chronic obstructive pulmonary disease (COPD), cancer, gastrointestinal disease, renal or liver disease and inflammatory conditions such as rheumatoid arthritis, inflammatory bowel disease

Progressive neurological disease⁵: dementia, Parkinson's disease, motor neurone disease (MND)

Acute illness⁵: where adequate food is not being consumed for more than 5 days (more commonly seen in a hospital than a community setting)

Debility⁴: frailty, immobility, old age, depression, recent discharge from hospital

Social issues⁵: poor support, housebound, difficulty obtaining or preparing food

Rehabilitation: after stroke⁵, injury⁴, cancer treatment⁴

End of Life/Palliative Care^{18,19}: tailor and adjust advice according to phase of illness

Barriers to GP diagnosis

Cost – belief it is
costly to treat
malnutrition



Breaking down barriers/changing perceptions

- Need to make sure that GPs are aware of the cost benefits of treating those at risk of malnutrition

Cost implications of malnutrition

The healthcare cost of managing individuals with malnutrition is three to four times greater than that of managing non-malnourished individuals, due to higher use of healthcare resources¹.

Malnourished people have¹:



Disease-related malnutrition costs in excess of £19 billion per annum in England alone, based on malnutrition prevalence figures and the associated costs of both health and social care¹.

- This breaks down to a cost of over £90 million per CCG based on 207 CCGs in England^{1,2}
- It is estimated that the cost of healthcare for a malnourished patient is £5763 (based on the point prevalence of malnutrition and annual expenditure on malnutrition) and £1645 for social care compared to that for non-malnourished patients of £1715 and £440, respectively¹

Tackling malnutrition can improve nutritional status, clinical outcomes, and reduce health care use¹.

- The National Institute of Health and Care Excellence has shown substantial cost savings can result from identifying and treating malnutrition: implementation of the Clinical Guideline 32: Nutrition Support for Adults¹⁴ and supporting Quality Standard 24¹⁵ have been shown to be high impact with respect to cost savings¹⁶
- The cost of managing malnutrition using prescribable nutrition support (including oral nutritional supplements, tube feeds and parenteral nutrition) is low at <2.5% of the total expenditure on malnutrition¹⁷

Breaking down barriers/changing perceptions

- Raising awareness amongst GPs
 - development of pathways and patient materials
- ## Managing Adult Malnutrition in the Community

The collage features several key documents:

- Managing Adult Malnutrition in the Community (2012):** A brochure with a green and blue wavy background. It includes the text "Including a pathway for the appropriate use of oral nutritional supplements (ONS)" and "Produced by a multi-professional consensus panel". Logos for NNF, RACGP, PCMA, and others are visible at the bottom.
- A Guide to Managing Adult Malnutrition in the Community (2017):** A brochure with a white background and a central illustration of a family. It also includes the text "Including a pathway for the appropriate use of Oral Nutritional Supplements (ONS)" and "Produced by a multi-professional consensus panel".
- Your Guide To Making the Most of Your Food - Advice for patients and carers:** A yellow leaflet with a central illustration of a family. It provides practical advice such as "Eat smaller meals with snacks and nourishing drinks in between" and "Try having a pudding or a snack a day such as full cream yogurt, ice cream, cake, custard, rice pudding".
- Eating Well - Advice for patients and carers:** A green leaflet with a central illustration of a family. It provides general advice on eating well, such as "You have been given this leaflet to help you eat well and keep as healthy as possible".
- Nutrition Drinks (known as Oral Nutritional Supplements) Advice for patients and carers:** A red leaflet with a central illustration of a family. It explains the importance of good nutrition and provides information on how to use oral nutritional supplements (ONS) effectively.

2012

2017

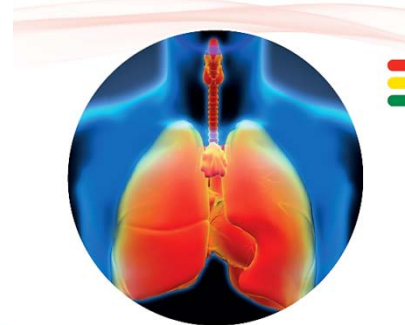
Breaking down barriers/changing perceptions

The malnutrition pathway has been featured in local guidance across the UK including the following key documents:

- NHS Guidance - Commissioning Excellent Nutrition and Hydration 2015-2018
- BAPEN - Malnutrition Matters: A Commitment to Act
- Medendiums' eGuidelines

Breaking down barriers/changing perceptions

- Managing Malnutrition in COPD (June 2016)



Managing Malnutrition in COPD

Including a pathway for the appropriate use of ONS to support community healthcare professionals



www.malnutritionpathway.co.uk/copd/

Managing Malnutrition in COPD
www.malnutritionpathway.co.uk/copd/

Identifying Malnutrition According to Risk Category Using 'MUST' - First Line Management Pathway

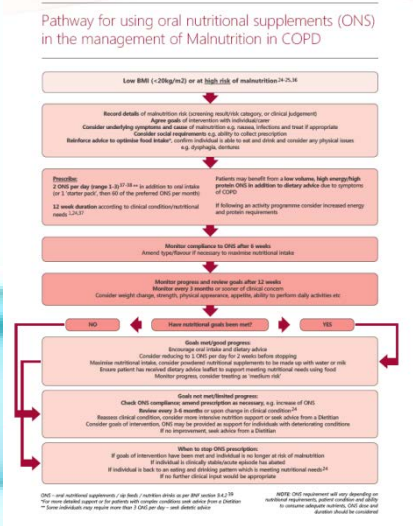
ONS score		Weight loss score	Acute disease effect score
1.5 (20kg)	Score 1	Highweight above 10% loss in 3-6 months	0 (No acute disease effect)
1.0 (15kg)	Score 2	10-15% loss	1 (Mild acute disease effect)
0.5 (5kg)	Score 3	5-10% loss	2 (Moderate acute disease effect)
0 (0kg)	Score 4	<5% loss	3 (Severe acute disease effect)

Risk Categories:

- Low risk - score 0:** Routine clinical care
- Medium risk - score 1 or 2:** Monitor weight and nutritional status, consider intervention if weight loss continues
- High risk - score 3 or more:** Urgent referral to dietitian

ONS (Oral Nutritional Supplement) criteria:

- ONS is indicated for malnourished patients with a MUST score of 2 or more.
- ONS is indicated for malnourished patients with a MUST score of 1 or 2 who are also at high risk of malnutrition.
- ONS is indicated for malnourished patients with a MUST score of 1 or 2 who are also at high risk of malnutrition and who are also at high risk of malnutrition.



ONS - oral nutritional supplement - 'big food' - nutrition drink in per litre water 1.5 x 170
 *The most suitable support for patients with complex conditions and/or who have a preference
 **Some individuals may require more than 1 ONS per day - see dietary advice
 NICE: ONS replacement will only be used in malnourished patients, patient condition and ability to consume adequate calories, ONS does not
 replace other nutritional interventions

Breaking down barriers/changing perceptions

- Developing a whole system approach:
 - involving dietitians, nurses, pharmacists, commissioners, carers,
 - ensuring information is shared at discharge
 - example of good practice in discharge from the dietetic team at Guy's and St Thomas' NHS Foundation Trust
- malnutritionpathway.co.uk/health-resources



"Ok, Ms. Feldman, it says on your chart that you were discharged yesterday."

Breaking down barriers/changing perceptions

- Integrating nutrition into all care pathways
 - Done for COPD and lung cancer
 - Other limiting conditions and chronic diseases to consider:
 - Cancer
 - Frailty
 - Dementia
 - Depression
 - IBD
 - Long list for consideration
 - Need to start incorporating nutrition into LOCAL pathways

What next?

- Closer working between professionals
- Raising awareness of key messages
- Sharing and implementing the pathway
- Clear discharge summaries
- Identifying audits
- Raising awareness amongst patients and carers
- Making malnutrition a CCG priority

References

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5. McGurk P et al. The burden of malnutrition in general practice. Gut 2012; 61 (Suppl 2): A18 (OC-042)
6. RCGP. Six Steps for Safer Practice. 2017.
7. Elia M, on behalf of the Malnutrition Action Group (BAPEN) and the National Institute for Health Research Southampton Biomedical Research Centre. The cost of malnutrition in England and potential cost savings from nutritional interventions (full report). 2015.<http://www.bapen.org.uk/pdfs/economic-report-full.pdf>.
8. NHS Clinical Commissioners; 2013 <http://www.nhscc.org/ccgs/> - based on costs from 2015 BAPEN report split over 207 CCGs in England.