OPPORTUNITIES FOR THE NUTRITION AGENDA WITHIN HEALTH AND SOCIAL INTEGRATION

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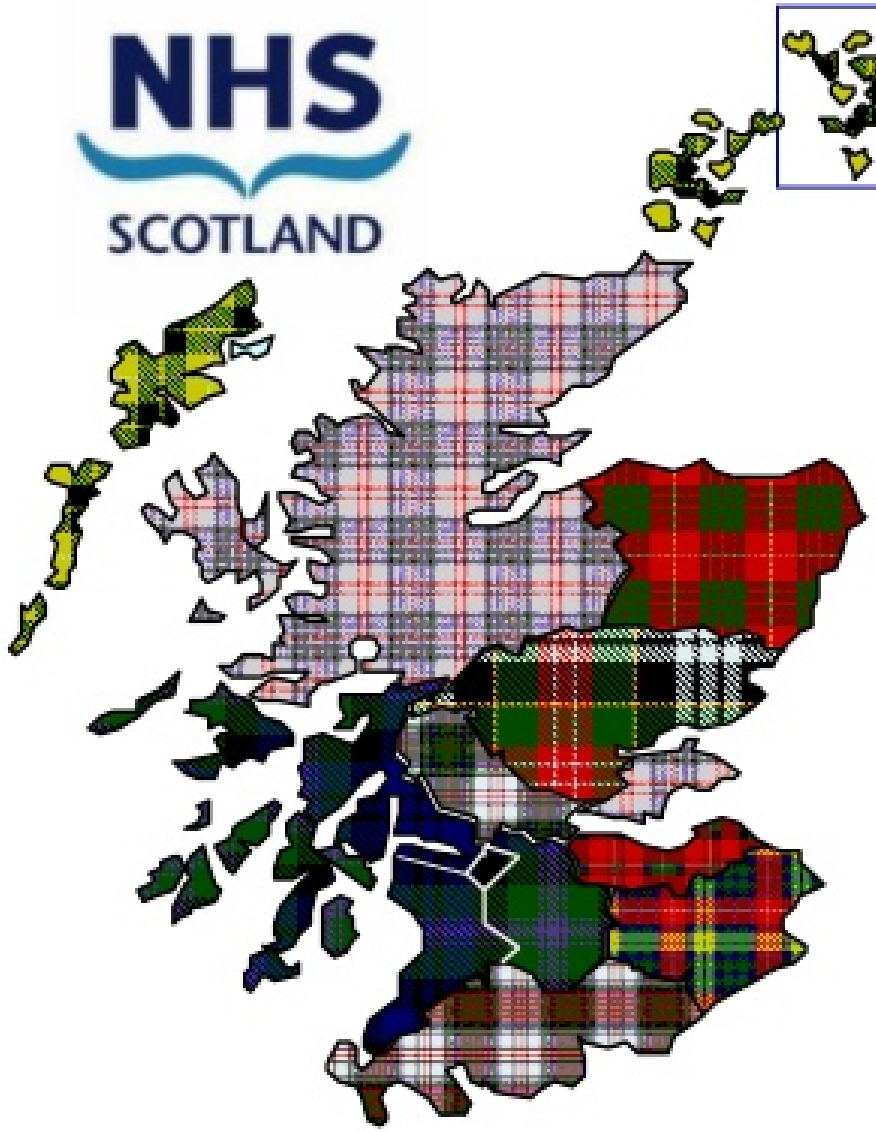
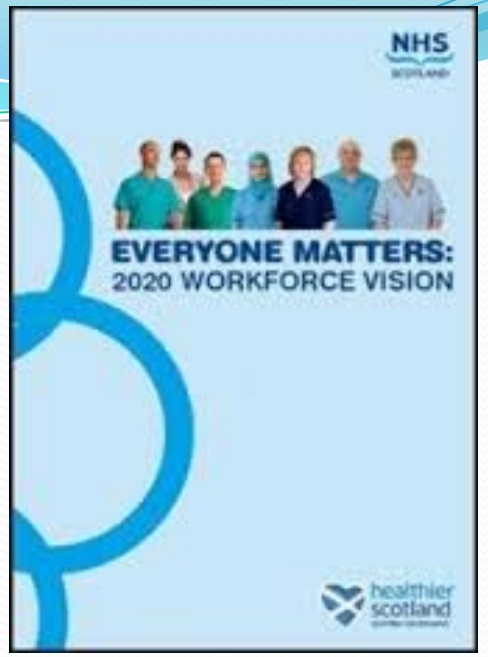
NHS SCOTLAND



- 5.2 million people
- £12 billion
- 14 Health Boards
- 8 Support Boards
- Emphasis on partnership and collaboration
- Moving to health and social care integration

ACTIVE & INDEPENDENT

LIVING IMPROVEMENT PROGRAMME



The right care for me is delivered at the right time

John's mobility is restricted after his recent fall. It's important to him that he maintains his independence and that he can look after himself. John's local health and social care team visit him at home at different times of the day to check he's ok, eating well and taking his medication. All the different services are working well together and this is enabling John to stay in his own home.

My individual circumstances are considered

Graham has a bipolar disorder and a heart condition. His GP referred him to a social worker specialising in mental health, and also the practice nurse who helped him understand his heart condition and how he could manage it. She signposted him to a local cardiac rehabilitation group. Through the social worker, Graham was put in touch with a peer support worker who has helped him to regain his hope

I am able to look after my own health and wellbeing

Following her diagnosis with dementia, Mrs Taylor and her family received a great deal of support from a specialist third sector organisation that the practice nurse put them in touch with. This included helping them to learn about self-management and the chance to join a peer support group in a nearby town. They found the mutual support provided by the group invaluable.

I coordinate my family's health and wellbeing

Jane cares for her husband who has MS and her frail mother who lives over 25 miles away. She has become increasingly depressed, worries constantly about her mum falling and has back pain from lifting her husband. Her GP put her in touch with the social work department. The local carers centre arranged a hoist and care workers to help shower and lift John. A community alarm, bed, chair sensor and falls detector have also been fitted in her mum's home which has lessened Jane's worry.

I get the support and resources I need to do my job well

Sharon is a Healthcare Support Worker and together with her other colleagues in health and in social care, they combine their broad range of skills and knowledge to deliver a joined-up service to those that they care for. This approach makes Sharon feel like she is not working in silo and it can avoid the scenario where the left hand doesn't know what the right is doing. She gets a great sense of satisfaction being in a team where the person being cared for receives the health and care outcomes that matter most to them.

Services and support are reliable and respond to what I say

Mr and Mrs Taylor's GP listened as they described their daily challenges with Mrs Taylor's dementia and diabetes. Mrs Taylor was no longer safe at home and they were both becoming isolated, experiencing symptoms of depression and anxiety. The GP, Dementia Specialist Nurse and an Occupational Therapist worked with the Taylors to agree the support that would enable them to stay well at home. The GP also arranged for a Diabetes Specialist Nurse to help Mr Taylor learn how to support his wife in managing her diabetes.

Support and services I use protect me from harm

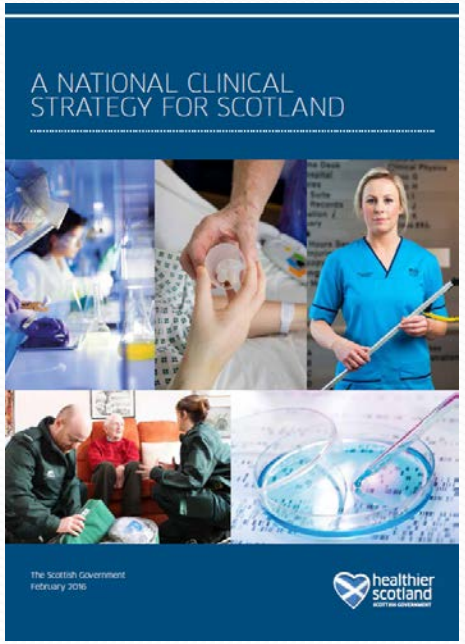
Tariq has Down's syndrome, an associated heart condition and visual impairment. At aged 20, one of his biggest priorities was to leave home and live in his own flat. His mother was worried about whether he would be safe living alone. Tariq's social worker arranged for his specialist heart nurse to join one of the transition planning meetings so they could talk through the issues. With Tariq, they agreed that they would find a flat for him where support is available if he needs it, and that any minor risks were worth taking.

I am able to live independently

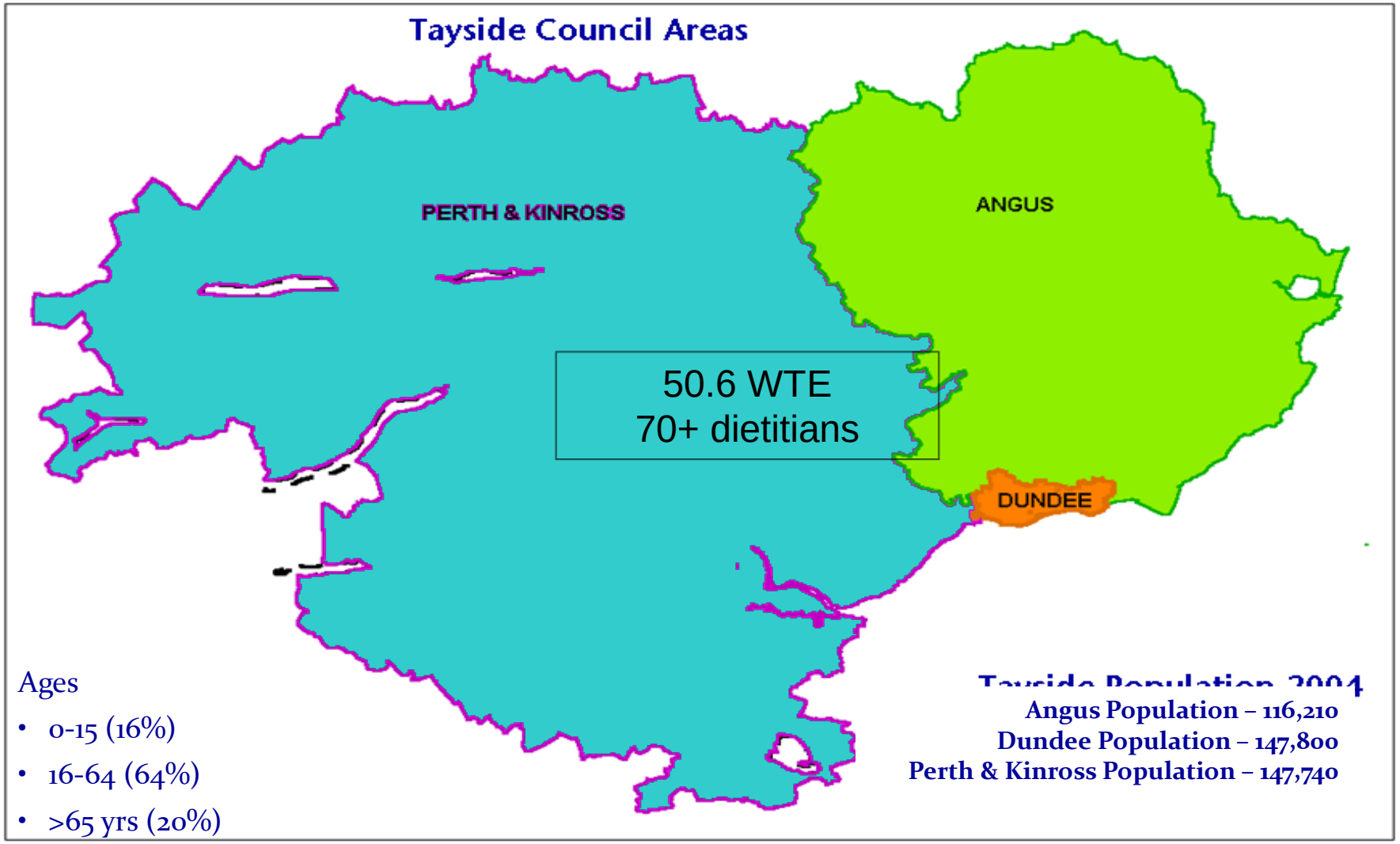
Since leaving school, Tariq has used a personal budget to employ a personal assistant to support him in his daily life. He has also used a small amount of this budget to pay for membership to his local swimming club, which has helped him to stay fit and meet new friends. Tariq continues to receive support from his social worker, GP and specialist heart nurse. This has helped him to self-manage his heart condition and visual impairment and to access different types of support when he needs it. He now feels confident in being able to live the life he has planned for.

I am supported to do the things that matter most to me

From infancy, Mary has had a muscle wasting condition and now requires 24-7 assistance with all aspects of her daily life to live independently at home. Suselle receives financial support to employ her own personal assistants who support her to live well and to do the things she wants to. It's important to Suselle that she has this choice, control and the flexibility in her own life.



Nutritional wellbeing of Tayside



Data source: GRO 2012 mid-year population estimates

Total population 411,749

2015 Nutrition and dietetic innovative clinical leadership model

- dietetic service leads
- collectively responsible for a multi-agency/multidisciplinary and whole systems approach to prevention and treatment of nutrition related disease.

- Weight Management
- Community Food & Health
- Therapeutic Nutrition
- Nutritional support

Integrated Joint Boards

Legislation to implement health and social care integration came in to force on April 2016, bringing NHS and local council care services under one partnership for each area.

In Tayside the IJBs deliver adult health and social care services.

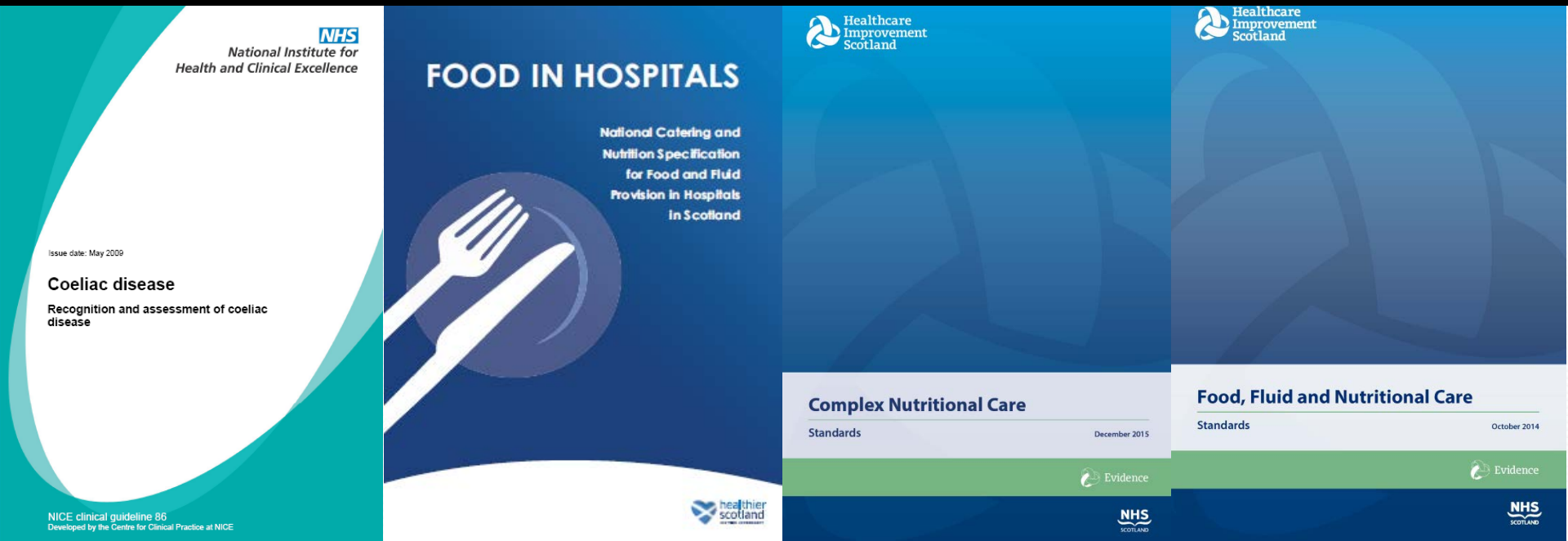
Local teams and health professionals across health and social care are working together to deliver quality, sustainable care and services resulting in improve outcomes for the population.

Carers and service-users will have a role to play in the work of the Board.

Tayside NHS functions include:

- Developing a single local health plan addressing health priorities
- Allocating resources to local priorities & to meet strategic objectives
- Implementing the Tayside Delivery Plan & managing performance

SCOTTISH GOVERNMENT NUTRITION POLICY



NHS Tayside Nutrition Network

- Obesity Prevention (women of childbearing age and children in Dundee)
- Maternal & Infant Nutrition – breastfeeding and infant formula milk feeding, maternal nutrition and family food skills
- Child Healthy Weight - East Play Learn Well (East End Dundee and Perth & Kinross)
- Oral Nutrition Support Pathway
- Health Promoting Health Service
- Modern Outpatient Programme – coeliac disease , IBS and IBD
- Food, Fluid & Nutritional Care in Hospitals

Scottish Government

- We will provide national leadership in relation to Modern Outpatient Programme

National Bodies

- We will provide national leadership in relation to the UNICEF Baby Friendly Initiative, the British Dietetic Association (Scotland) and British Association for Parenteral and Enteral Nutrition (Scotland).

Outcomes Framework:

- Maternal & Infant Nutrition Framework
- Child Healthy Weight
- Adult Weight Management
- BDA Centre for Education Development
- NHS Tayside Oral Nutrition Support

Prevalence of malnutrition

Nutrition Screening week 2007-2011

- 661 hospital centres
- 34,699 adult patients
- 29% ‘at risk’ of malnutrition medium & high risk according to ‘MUST’ criteria
- Source of admission of those ‘at risk’
  - 35% other hospitals
  - 32% other wards
  - 50% care homes
  - 27% home

BAPEN
Advancing Clinical Nutrition

Source: BAPEN Survey NSW 07-11

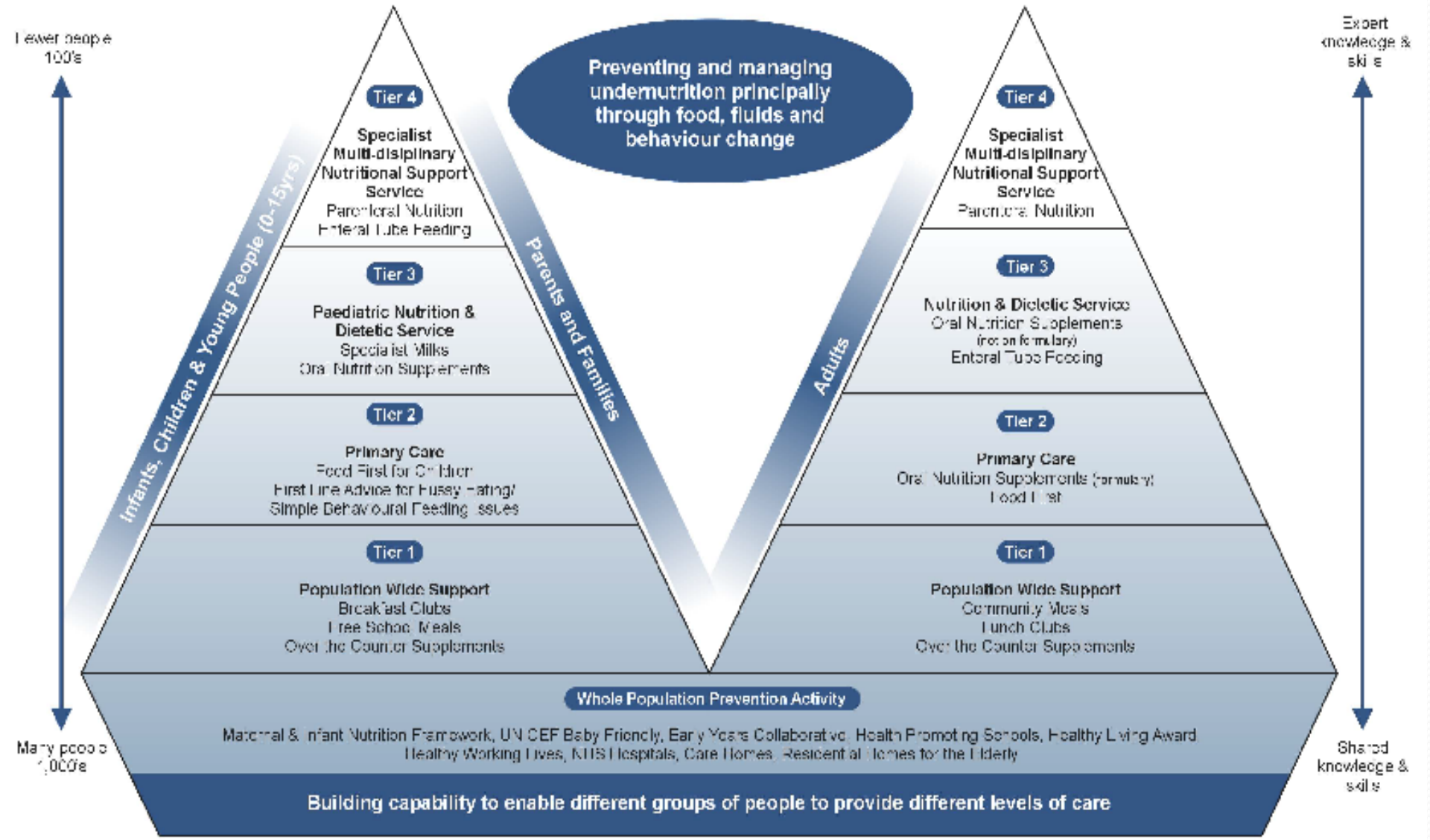
NHS Tayside adult population at risk of malnutrition

	No. of admissions	Prevalence of malnutrition (%)	NHST no.
Care homes	289	36	100
Mental health unit admissions	1 912	~20	382
Hospital admissions	82 813	16	13 250
General population	-	~5%	20 100

BAPEN Survey Nutrition Screening Week 2011; ISD 2011

NHS Tayside Malnutrition Framework

Dec 2013



Partnership working

Prevention and management of undernutrition

- Early identification of risk
- Signposting to early interventions
- Community and nurse led management
- Appropriate prescribing


Ensure practice is evidence based including Food First approaches
Prevent undernutrition occurring/early intervention
Shift care from secondary to community care
More efficient dietetic service
Utilise technology enabled care
Improve patient experience
Allow self-care
Reduce inequalities
Decrease GP workload

ADULT ORAL NUTRITIONAL SUPPORT SERVICE REDESIGN 2016223

AIM Statement	Primary Drivers	Secondary Drivers

AIM Statement

Ensure 100% of adult patients follow NHS Tayside's Adult Oral Nutrition Support (ONS) pathway

Primary Drivers

ONS PRESCRIBING MODEL
Application of an efficient prescribing criteria for ONS in community

ONS PATHWAY - HOSPITAL
Implementation of ONS pathway within NHST hospitals

ONS PATHWAY - COMMUNITY
Implementation of AONS pathway within community

TRAINING & EDUCATION
Health & social care personnel have knowledge, skills & competencies to deliver the ONS pathway

PREVENTION & ANTICIPATORY CARE
Improve awareness and knowledge in communities to empower people to self-manage their own nutritional well-being

Secondary Drivers

1. Identify prescribing data
2. Develop best value ONS formulary
3. Determine criteria for ONS prescribing by a dietitian
4. Determine a process to review ONS prescribing in Tayside
5. Create a data base for ONS
6. Implement a phased review of ONS prescribing across Tayside general practices staring with highest prescribers
7. Identify financial outcome

1. Change dietetic referral criteria from 'MUST' ≥2 to from 'MUST' ≥3
2. Standardise first line ONS for hospital use
3. Provide direct access to ONS at ward level
4. Implement direct access policy to ONS at ward level
5. Support ward staff through education (see training & education)
6. Identify financial, staff experience, patient experience & capacity outcomes

1. Remodel ONS service provision to the new Gluten Free Food scheme (led by dietitians & community pharmacists)
2. Undertake an equality impact assessment
3. Create a central dietetic referral system combining community and hospital services
4. Determine a process to implement ONS pathway across Tayside
5. Implement the ONS pathway
6. Develop new care home pathway, develop new ordering system and stop GP10 prescribing for ONS
7. Identify financial, staff experience, patient experience, capacity, grey costs (e.g.GP time) outcomes

Assess training needs & deliver training to relevant health and social care personnel e.g.
1.Management of malnutrition
2.Nutrition risk assessment using 'MUST'
3.Nutritional assessment
4.ONS pathway
5.ONS product awareness
Improve access to e-health resources & support

1. Engage with communities to establish baseline knowledge and understanding relating to undernutrition
2. Identify existing sources of nutritional advice and support and signpost communities to these resources
3. Improve and increased knowledge of undernutrition in communities by developing and delivering training resources to communities and care providers
4. To promote and raise awareness of undernutrition and nutritional well-being
5. Working together to increase capacity within communities based on early intervention and an asset based approach
6. Development of resources for self diagnosis & self help materials to support the early detection and prevention of undernutrition in the community
7. Develop service level agreements on food, fluid and nutritional care with partner organisations where this a need is identified

PREVENTION & ANTICIPATORY CARE

Improve awareness and knowledge in communities to empower people to self-manage their own nutritional well-being

Application of an efficient ONS Prescribing Model

BEST VALUE

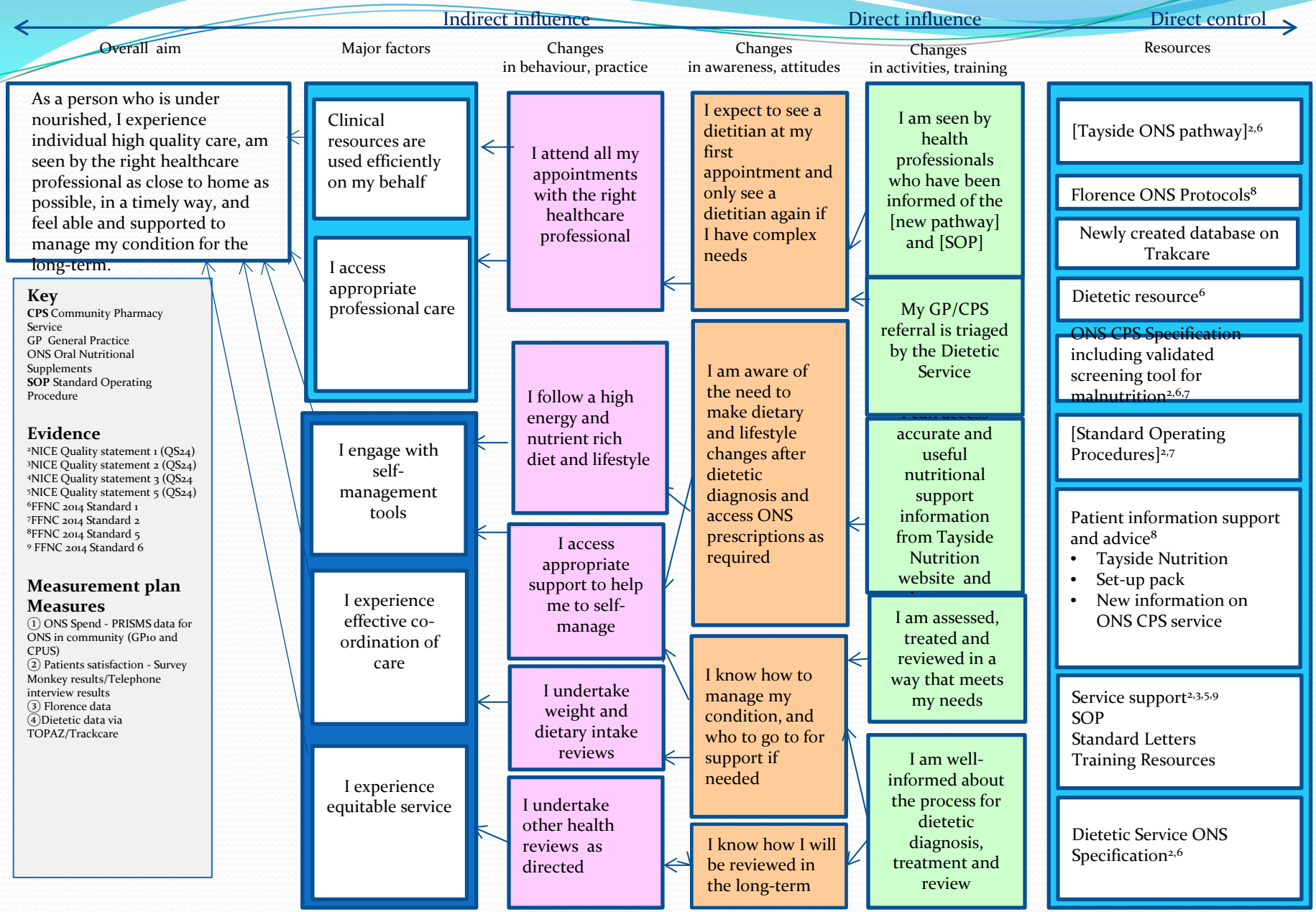
Huge Rx spend

NEED TO REDUCE WASTE, VARIATION – inappropriate prescribing

Need to reduce harm – better identification and management of risk no reviews – BMIs, long term repeat Rx

Release capacity and become innovators

NHS Tayside Oral Nutritional Supplements redesign logic model



Key

CPS Community Pharmacy Service
GP General Practice
ONS Oral Nutritional Supplements
SOP Standard Operating Procedure

Evidence

[2]NICE Quality statement 1 (QS24)
[3]NICE Quality statement 2 (QS24)
[4]NICE Quality statement 3 (QS24
[5]NICE Quality statement 5 (QS24)
[6]FFNC 2014 Standard 1
[7]FFNC 2014 Standard 2
[8]FFNC 2014 Standard 5
[9] FFNC 2014 Standard 6

Measurement plan

Measures

① ONS Spend - PRISMS data for ONS in community (GP10 and CPUS)
② Patients satisfaction - Survey Monkey results/Telephone interview results
③ Florence data
④Dietetic data via TOPAZ/Trackcare

[1] **Model adapted from Reed et al. (2014), available from http://qualitysafety.bmj.com/content/early/2014/10/15/bmjqs-2014-003103.full (accessed April 2016)**


Care Homes
Hospitals
Community

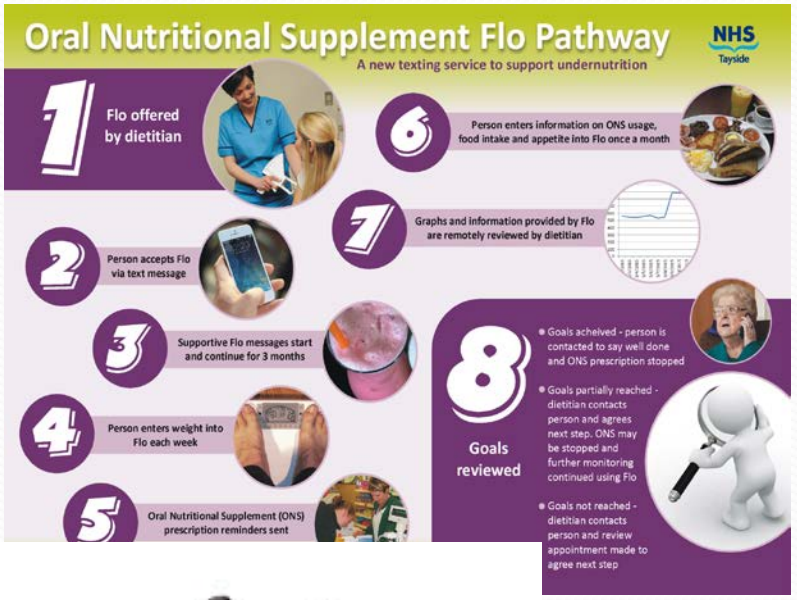
1. Change referral criteria from ‘MUST’ ≥2 to from ‘MUST’ ≥3
2. Standardise first line ONS for hospital use
3. Provide direct access to ONS at ward level
4. Support staff through education
5. Identify financial, staff experience, patient experience & capacity outcomes

TRAINING & EDUCATION

Health & social care personnel have knowledge, skills & competencies to deliver the ONS pathway

1. Assess training needs & deliver training to relevant health and social care personnel e.g.
    1. Management of malnutrition
    2. Nutrition risk assessment using ‘MUST’
    3. Nutritional assessment
    4. ONS pathway
    5. ONS product awareness
2. Improve access to e-health resources & support

Home & Mobile Health Monitoring



ONCE FOR SCOTLAND

• Reporting to the Effective Prescribing Programme Board and Effective Prescribing and Therapeutics Branch

•To review and advise on the current prescribing of ONS and the future development of prescribing practice and processes across NHS Scotland

• To promote and improve quality, safe and cost effective ONS prescribing for the treatment of malnutrition

• Report with recommendations for implementation to improve patient care and deliver efficient management and monitoring of prescribing ONS across acute and primary care

>>>> NUTRITION

- Population based approach
  - Right clinician
  - Right time
  - Right place
  - ONS
    - Right product


Thank You