

# Delivering Core NHS and Care Services during the Pandemic and Beyond

## British Dietetic Association Consultation Response

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### About Dietitians and the BDA

The BDA are the trade union and professional body representing the UK's dietetic profession. We are one of the oldest and most experienced nutrition organisations in the world, having been first founded in 1936.

Dietitians are the clinical nutrition experts, and the only nutrition professionals regulated by law. Dietitians use the most up-to-date public health and scientific research on food, health and disease which they translate into practical and individualised advice. They work with people with chronic and acute health problems as well as supporting overall public health.

### How to achieve an appropriate balance between coronavirus and 'ordinary' health and care demand?

Putting in place clear triage systems to establish priority patients will be vital, as it will not be possible to simply "return to normal" when reopening outpatient and community health services. This should include coherent and clear triage through primary care, to ensure people can access services. Government will need to find means of increasing capacity beyond the emergency phase of the COVID-19 response.

Health and Care services will need to provide guidance and support for community teams to re-prioritise staff that were redeployed in the acute setting back into community and primary care settings and retention of AHPs that have come back onto the HCPC register

Our members have highlighted their biggest concern are with the following patients' groups:

- Low numbers of strokes and MI's presenting
- Late presentation with cancers
- Increased rates of malnutrition in the community
- Negative impacts on people living with eating disorders
- Care homes, which typically have high rates of malnutrition, are a particular concern with staff turnover and reduced access to care homes during the current situation
- Ongoing provision of specialist weight management services

Prevention activities will also need to come back online if we want to continue to drive down future demand.

### Meeting the wave of pent-up demand for health and care services that have been delayed due to the coronavirus outbreak

It is essential that we retain the staff that have come back onto the HCPC register in response to COVID-19. This will require appropriate support and compensation. Equally, government should look at how it can rapidly expand the health and social care workforce to make up for many years of significant under investment.

Specifically, in relation to diet and nutrition, the small dietetic workforce will need to work to train and support others to provide services to those that need them on top of an increased workload from COVID-19 patients requiring nutrition support in both the acute and community setting.

Upskilling and freeing dietitians and other AHPs to play a bigger role will improve patient outcomes, reduce pressure on other services. We would in particular like to see a wider range of professionals, including dietitians, given the ability to train as independent prescribers<sup>1</sup>.

The third/voluntary sector will likely need to play a key role to support health and social care services. Already, volunteers, friends and family have been essential in ensuring patients can access food and avoid negative impacts of social isolation. Charities have struggled as a result of the reduction in donations, cancellation of fundraising activities, while facing significantly increased demand for their services. Government needs to bolster and extend its support to the charitable sector, as well as taking steps to address the causes of the issues that require some charities to exist at all, in particular food banks and other forms of support for those unable to afford to eat.

Systems such as the GoodSam app have been successful and could be extended and further supported. NHS volunteers may need to be encouraged to continue their support beyond the crisis phase of the pandemic, but this should not be regarded as a long-term solution to staffing issues.

### **Meeting extra demand for mental health services as a result of the societal and economic impacts of lockdown**

Again, the third/voluntary sector will likely need to play a role to support mental health and social care services. However, government will need to consider whether it is realistic to expect this to continue indefinitely, especially when many more people return to work. The UK is already heavily reliant upon volunteer carers, and more support is needed to help them manage.

### **Meeting the needs of rapidly discharged hospital patients with a higher level of complexity**

#### **Those discharged from hospital with COVID**

There does not appear to be a clear pathway from discharge to rehabilitation support in the community setting.

From what we know of COVID, patients may experience poor appetite, dysphagia, muscle loss, frailty, malnutrition, PTSD and global weakness from ICU, therefore, to address all of these potential issues, an MDT approach is required. Dietitians must form a part of this MDT. Discharge documentation needs to clearly state the rehabilitation requirements for each patient and an MDT service needs to be there to support these requirements in the community. This is in line with guidance from the British Society of Rehabilitation Medicine<sup>2</sup>

A clear triage system outlining who is responsible for each stage is required. A huge concern here is that patients are being rapidly discharged without any follow-up and will present at their GP practice/out of hours weeks/months later with ongoing issues relating to frailty/malnutrition.

#### **Those in the community with COVID that have not been into hospital but need support**

All dietetic services in the community that have provided us with information have reported that they are not receiving referrals for patients with COVID-19. We know these patients require dietetic support but there does not seem to be a clear pathway to refer. This is likely to be for two reasons:

- Discharge information is not highlighting nutritional concerns. We know from previous data that nutritional risk is rarely highlighted on discharge documentation (nutritional screening was only consistently recorded in 18% of discharge documentation (1))
- Patients are not accessing services in light of social distancing measures – not attending their GP/not seeing other HCP that would normally refer to dietetics

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<sup>1</sup> <https://www.bda.uk.com/uploads/assets/ebb3cfd5-c689-478f-aef57ba592959d88/Letter-to-Jo-Churchill-re-Prescribing-Rights-May-2020-FINAL-for-web.pdf>

<sup>2</sup> <https://www.bsrm.org.uk/publications/latest-news/post/39-covid-19-bsrm-position-on-rehabilitation>.

To address this, a discharge pathway mentioned above needs to be implemented along with screening for malnutrition risk by all frontline staff (GPs/ nurses/ carers). First line advice can be provided as per malnutrition pathways and then those more complex to be referred to dietetic teams. It will also be important to ensure community health services have access to appropriate PPE at the same level as acute, hospital based staff.

## **Providing healthcare to vulnerable groups who are shielding**

### **Malnutrition as a focus**

In normal times, over three million people, over 95% of them in the community, are at risk of or suffering from malnutrition (undernutrition). Many of those most at risk will also be those categorised as “at risk” groups for COVID-19, and may well be self-isolating or shielding. Many of these people will be at risk of or suffering malnutrition not as a result of food poverty, but other issues which make it more difficult for them to eat a healthy diet.

Although hard statistics do not yet exist, it is almost certain that COVID-19 and the measures taken to address it will have exacerbated this problem. Loneliness, a lack of physical activity, stress and anxiety and more difficulty accessing food will all have increased risk. It is vital that a comprehensive approach to screening for and addressing malnutrition in the community is put in place, bringing together dietitians, other AHPs, community nursing teams, carers and others. Malnutrition increases risk when someone contracts COVID-19, and also increases risk of other issues such as falls and frailty. With appropriate support, it can be prevented, but the most difficult task can be identifying it.

### **Technology**

Utilising technology is essential here to provide access to safe services bearing in mind social distancing measures. Some examples include:

- Telephone/video consultations
- E-learning for HCP and patients to provide knowledge and support to meet the increased demand on services
- Electronic systems to manage waiting lists

In order to deliver these, fast-tracked improvements to IT infrastructure are essential, these include - video consultation software and well as increased access to cameras, headsets, laptops, VPNs etc. We have learned of some services sharing laptops between numerous members of staff. This reduces efficiency and poses infection control risks. Others have had to take home desktop PCs to continue providing services from home.

One barrier is that there is no consistent approach across NHS to which apps, online services, etc. are acceptable or not. The NHS routinely prevents staff using comms methods readily accepted in business and commercial settings, even when patient info is not being shared. This NHS frustrates the ability of HCPs to communicate with each other, share info, share best practice, etc.

A concern would be that remote consultations becomes the norm in all future consultations. Although in many situations it is safe and efficient, we must appreciate that this is not always the safest option. For example, a call with an older adult will not give you a true picture of their ability to access and prepare foods or assess muscle strength/function. Virtual consultations do not allow for non-verbal communication cues to allow the HPC to assess a patient's mental health – reducing referrals to accessing the support they need.

## **Supporting mass testing and vaccination once they become available.**

Mass testing for healthcare staff will be vital to ensure a speedy return to work to support the expected increased demand.

## How to ensure that positive changes that have taken place in health and social care as a result of the pandemic are not lost as services normalise.

It should be remembered that a great deal of the remarkable response to COVID-19 has occurred as a result of good will and the inherent desire on the part of health and care professionals to help others during a time of crisis. Healthcare staff should not be expected to continue delivering services under high pressure without appropriate support and compensation. Even a return to “normal”, to services at the level they were before the pandemic, would be to return to services that were overstretched and under resourced. COVID-19 should serve as a warning of how fragile our system is as well as how remarkably innovative and adaptable our NHS and care services are.

We would hope that services can built upon successful communication between acute and community services/trusts. However, we also know that under the pressure of COVID-19, many patients are being discharged without appropriate plans in place for when they go into community services.

Dietitians and indeed all healthcare professionals understand the value of a multidisciplinary team, and we should seek to capture and proliferate the many good practice examples for effective MDT working. Dietitians and AHPs can and should form a central part of MDTs from acute to community care.

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