



**BAPEN**

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# Malnutrition and Nutritional Care Survey in Adults

**UK Malnutrition Awareness Week, October 2023**

**Rebecca Stratton (Editor) and Dr Abbie Cawood on behalf of the Malnutrition  
Action Group of BAPEN.**

# MAG

Malnutrition Action Group  
A Standing Committee of BAPEN

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This report was produced on behalf of BAPEN by the Malnutrition Action Group Chair and Committee of 2023, in October 2024.

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## Key points

The BAPEN malnutrition and nutritional care survey, undertaken in November 2023 in conjunction with the UK Malnutrition Awareness Week, included 2250 adults (50% male; mean age 63 years, mean BMI 25.1 kg/m<sup>2</sup>) from hospitals (69%) and a variety of community settings (31%) across the UK and the Republic of Ireland.

Patients had a range of primary diagnoses, including neurological conditions (19%), gastrointestinal conditions (15%), frailty (11%), cardiovascular (9%) and respiratory (7%) conditions, and cancer (7%). Around one fifth of patients (21%) were underweight (BMI < 20kg/m<sup>2</sup>), 18% were obese (BMI ≥ 30kg/m<sup>2</sup>) and 22% had unplanned weight loss.

Overall, 48% of adults were at risk of malnutrition (12% medium and 36% high risk) using the 'Malnutrition Universal Screening Tool' ('MUST'). Malnutrition was common in community settings, including in those in their own homes (49% at risk) and in residents in care homes (42% at risk). In hospitals, 47% of patients were at risk of malnutrition. The highest prevalence of individuals at risk of malnutrition (where over 50% were at medium and high risk with 'MUST') was in those with gastrointestinal conditions, cancer, cardiovascular conditions, COVID-19 and those with trauma and orthopaedic conditions.

Compared to the last survey, nutritional care plans were in place for a lower proportion of individuals overall (56% vs. 62% in 2022) and for medium (62% vs. 71% in 2022) and high risk patients (73% vs. 91% in 2022) respectively. Of the care plans that were in place (which could include more than one intervention), most (89%) included food-based interventions and around two thirds had oral nutritional supplements (mostly ready-made liquids). Enteral tube feeding was recorded in the care plans of 41% of patients and PN in the care plans of 65 individuals, likely reflecting the centres participating in the survey.

In summary, this survey suggests that the prevalence of malnutrition remains high across the countries and regions that took part, as in previous years surveys. Nutritional care plans were only present in just over half of the patients surveyed. Although larger national surveys are needed to be fully representative of the population, these results suggest a need to reinforce the importance of screening for malnutrition and prompt, effective management to relieve the burden of this condition on individuals and society.

## Purpose & Methods

This BAPEN survey aimed to assess the prevalence of malnutrition according to the Malnutrition Universal Screening Tool ('MUST')(1) and the use of nutritional care across any setting in the UK in 2023. BAPEN has undertaken surveys over many years to assess the extent of malnutrition in different health care settings across the UK (2-6). Similar to previous BAPEN surveys (2019-2022) (2- 5), this survey of the prevalence of malnutrition and nutritional care, used the BAPEN online portal to collect data (see Appendix A). The designated period of data collection was 6<sup>th</sup> to 30<sup>th</sup> November 2023, coinciding with UK Malnutrition Awareness Week 2023. An invitation letter inviting organisations and individuals across health and social care settings to register to participate in the survey was sent out (see Appendix A). Non identifiable data were entered by health or social care professionals for each individual screened as follows (and see Appendix B for the questions):

### Individual Descriptive Data

The following information was collected for each individual:

- Location of residence (Hospital, Community Hospital/Rehabilitation Unit, Own Home, Care Home, Other)
- Length of stay in the location they resided (if applicable)
- Age
- Gender
- Primary diagnosis (choice of 1): Cancer, Cardiovascular (e.g. cardiovascular disease, coronary artery disease), COVID-19, Frailty, Genito/renal, Gastrointestinal (e.g. Crohn's, colitis), Haematology, Mental health (e.g. depression, anxiety), Musculoskeletal (e.g. arthritis), Neurological (e.g. stroke, motor neurone disease, dementia, Alzheimer's), Respiratory (e.g. chronic obstructive pulmonary disease, cystic fibrosis), Trauma and orthopaedic, Surgical, No disease or Other (free text)

## 'MUST'

Data required to complete the Malnutrition Universal Screening Tool ('MUST', see Appendix C) for each individual were entered by the health or social care professional in either metric or imperial units (e.g. weight, height, previous weight or weight lost over 3-6 months).

Body mass index (BMI) and percentage unintentional weight loss were automatically calculated as were the BMI and weight loss scores (**Steps 1 and 2 of 'MUST'**) in the online portal.

The presence of an acute disease effect (**Step 3 of 'MUST'**; 'if the individual was acutely ill and there has been or is likely to be no nutritional intake for more than 5 days') was answered by health or social care professionals and the relevant score generated.

The overall calculation of the 'MUST' score (0 to 6) and 'MUST' category (low, medium, high) (**Step 4 of 'MUST'**) was automated within the online portal.

## Nutritional care

The survey also asked if there was a malnutrition management plan in place for each individual and if so, the treatment options that were part of the care plan (See Table 1), which could include

- food based interventions and dietary counselling
- oral nutritional supplements (ONS)
- enteral tube feeding (ETF)
- parenteral nutrition (PN)

**Table 1: Nutritional care plan treatment options**

Food based intervention	Snacks Diet sheet Fortified foods with food ingredients Fortified foods with modular feeds Dietary counselling by dietitian Other (please specify)
Oral nutritional supplements	Ready-made liquid 1.0kcal/ml Ready-made liquid 1.5kcal/ml Ready-made liquid 1.6kcal/ml Ready-made liquid > 2kcal/ml Pre thickened Dessert style Powder Other (please specify)
Enteral Tube feeding	Continuous Bolus Energy density < 1kcal/ml Energy density 1-1.5kcal/ml Energy density 1.6-2kcal/ml Energy density >2kcal/ml Fibre containing High protein Peptide/amino acid Blenderised diet Other (please specify)
Parenteral Nutrition (PN)	Yes <span style="float: right;">No</span>
If yes, is PN managed by a nutrition support team	Yes <span style="float: right;">No</span>
PN Route	Cannula Central Line Peripheral Line Other (please specify)

# Results

## Individual descriptive data

This survey included 2250 individuals whose anonymised data were entered into the BAPEN online portal. All data collation and analysis were undertaken independently by the NHS South, Central and West Transformation Directorate.

### Location

In the survey, 1543 individuals were in hospital (69%). The remaining 31% lived in community settings, including in their own home (8.6%), a community hospital/rehabilitation unit (10%), a care home (7.7%) or mental health units (MHU) (4.6%). For those in institutions, there was a wide-ranging length of stay (range from 0 to > 100 days reported) but most (80%, n 1183) were < 20 days.

Most individuals screened lived in England (70%; n 1579), or Wales (21%, n 475), with a few individuals living in Scotland (5%, n 111), Northern Ireland (1%, n 32) and Republic of Ireland (2%, n 53) (Table 2).

The counties providing more than 40 screened individuals were from Wales (Carmarthenshire (n 225), Ceredigion (n 69), Gwent (n 44), Pembrokeshire (n 54)) and England (Dorset (n 60), Greater London (n 64), Hampshire (n 80), Leicestershire (n 172), Staffordshire (n 260), Surrey (n 292), West Midlands (n 483)).

**Table 2: Country of individuals screened**

Country	Frequency	%
England	1579	70
Wales	475	21
Scotland	111	5
Northern Ireland	32	1
Republic of Ireland	53	2
<b>Total</b>	<b>2250</b>	<b>100%</b>



## Age, gender and primary diagnosis

There was an even split of gender (50% for males and females) and a wide range of ages (mean 63, range 16 – 105 years). Over one third of individuals (36%, n 800) were over 75 years and 73% were over 50 years.

There were many primary diagnostic categories, with the most common ones being neurological conditions (e.g. stroke, Motor Neurone Disease, dementia) (19%), gastrointestinal conditions (15%), frailty (11%), cardiovascular conditions (e.g. ischaemia, coronary artery disease) (9%), respiratory conditions (e.g. COPD, cystic fibrosis) (7%), cancer (7%) and musculoskeletal conditions (5%).

## 'MUST'

Overall, 48% of adults were at risk of malnutrition (12% medium and 36% high risk) and 52% were at low risk of malnutrition (see Figure 1).

**Figure 1: Proportion of individuals according to malnutrition risk ('MUST')**

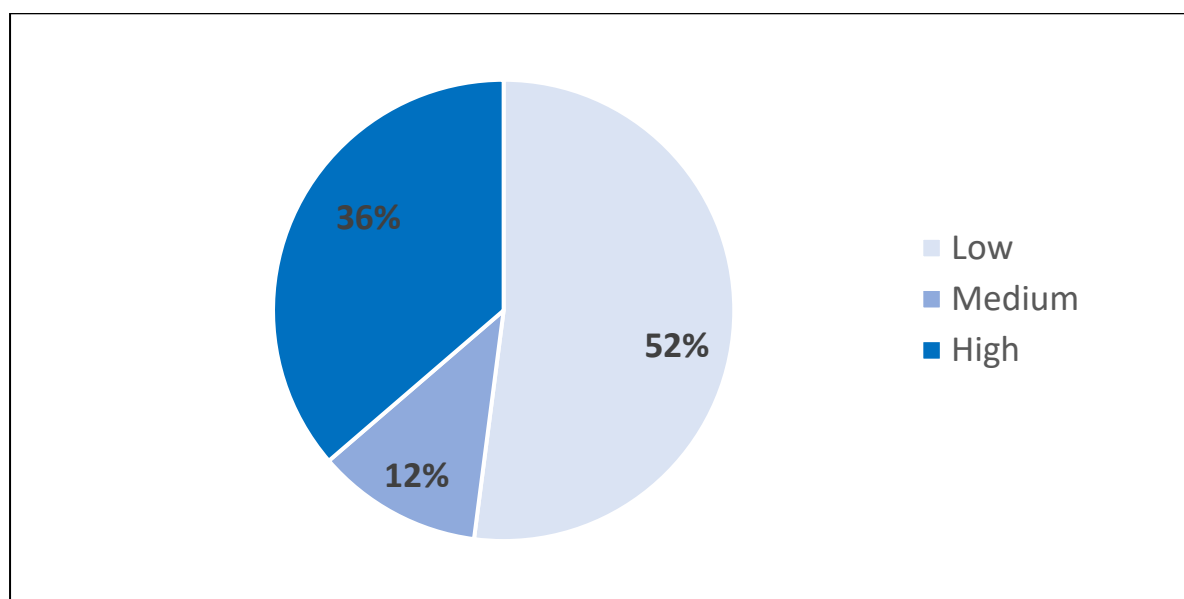


Table 3 summarises the prevalence of malnutrition risk by country and by region where sufficient data was collected.

Mean BMI was 25.1 (SD 6.8) kg/m<sup>2</sup> for those with weight and height data. Around one fifth of individuals were underweight (9% BMI 18.5-20kg/m<sup>2</sup> (BMI score 1); 12% BMI < 18.5kg/m<sup>2</sup> (BMI score 2)) with the majority (78%) having a BMI score of 0 (including 18% who were obese (BMI >30kg/m<sup>2</sup>)).

Around one quarter (22%) of individuals had unplanned weight loss of 5% or more, with 11% having 5-10% unplanned weight loss (weight loss score 1) and 11% having >10% weight loss (weight loss score 2).

Twenty-one per cent of individuals had an acute disease effect score (step 3 of 'MUST').

**Table 3: Prevalence of malnutrition risk by country and region**

Country/Region	Low (%)	Medium (%)	High (%)	n*
<b>England</b>	<b>51</b>	<b>11</b>	<b>37</b>	<b>1579</b>
<b>E Midlands</b>	60	56	34	175
<b>London</b>	47	17	36	60
<b>SE England</b>	52	10	38	417
<b>SW England</b>	74	15	11	66
<b>West Midlands</b>	51	12	37	760
<b>Wales</b>	<b>57</b>	<b>11</b>	<b>32</b>	<b>475</b>
<b>Mid Wales</b>	46	19	35	70
<b>SE Wales</b>	54	8	38	72
<b>SW Wales</b>	64	9	27	286
<b>Scotland</b>	<b>50</b>	<b>13</b>	<b>38</b>	<b>111</b>
<b>N Ireland</b>	<b>52</b>	-	<b>48</b>	<b>32</b>
<b>Rep Ireland</b>	<b>40</b>	<b>26</b>	<b>34</b>	<b>53</b>
<b>S. Ireland</b>	45	27	27	44

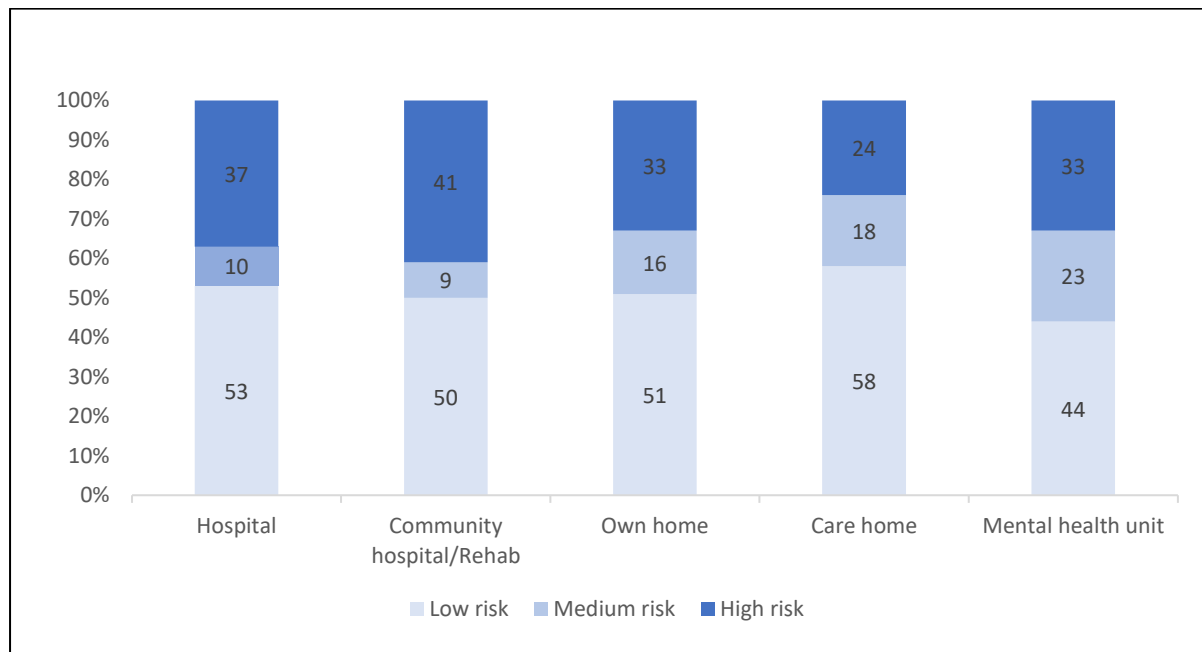
*Regions with 40 or more individuals presented only. Northern Ireland presented as country level \*Total n may differ if country/region not documented.*

## 'MUST' by Setting

Malnutrition prevalence varied by setting (see Figure 2). In hospitals, 47% of patients were at risk of malnutrition and across different community settings, malnutrition was also highly prevalent (own homes (49% at risk), residents in

care homes (42% at risk), individuals in community hospitals/rehab (50%) and in Mental Health Units (56%).

**Figure 2: Prevalence of malnutrition by setting**



## ‘MUST’ by Disease State

Malnutrition prevalence varied across the different diagnostic categories of individuals in the survey (Table 4).

The highest prevalence of individuals at risk of malnutrition (where over 50% were at medium and high risk with ‘MUST’) was in those with COVID-19, gastrointestinal diseases, cancer, cardiovascular conditions and those with trauma and orthopaedic conditions.

For some primary diagnostic categories, there were a limited number of patients included within the survey ( $n < 40$ ), so the data on malnutrition prevalence was not shown as it is unlikely to be representative.

**Table 4: Prevalence of malnutrition according to classification of primary diagnosis**

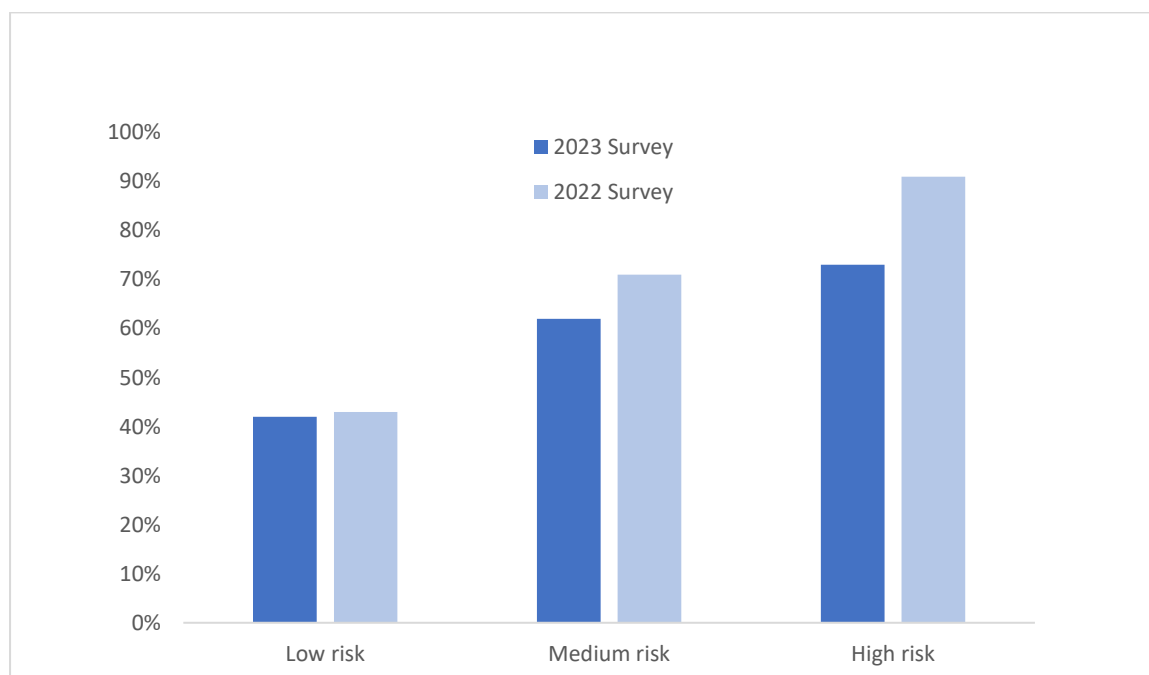
Primary diagnostic category	Low risk (%)	At risk (%) (Medium + High risk)
Cancer (n 150)	48	52
Cardiovascular diseases (n 200)	48	52
COVID-19 (n 46)	41	59
Frailty (n 241)	52	48
Gastrointestinal diseases (n 329)	43	57
Genito/Renal (n 92)	70	30
Mental Health (n 40)	53	47
Musculoskeletal (n 114)	56	44
Neurological diseases (n 420)	56	44
Respiratory (n 162)	57	43
Trauma & orthopaedics (n 139)	47	53

NOTE: Other diseases/conditions not shown as n <40

## Nutritional Care Plans

Compared to last year’s survey (2022), nutritional care plans were in place for a lower proportion of patients overall (56% in 2023 vs. 62% in 2022) and for a lower proportion of medium (62% vs. 71% in 2022) and high risk patients (73% vs. 91% in 2022) respectively (Figure 3).

**Figure 3: Proportion of patients with a nutritional care plan according to 'MUST' category (2022 and 2023 surveys)**



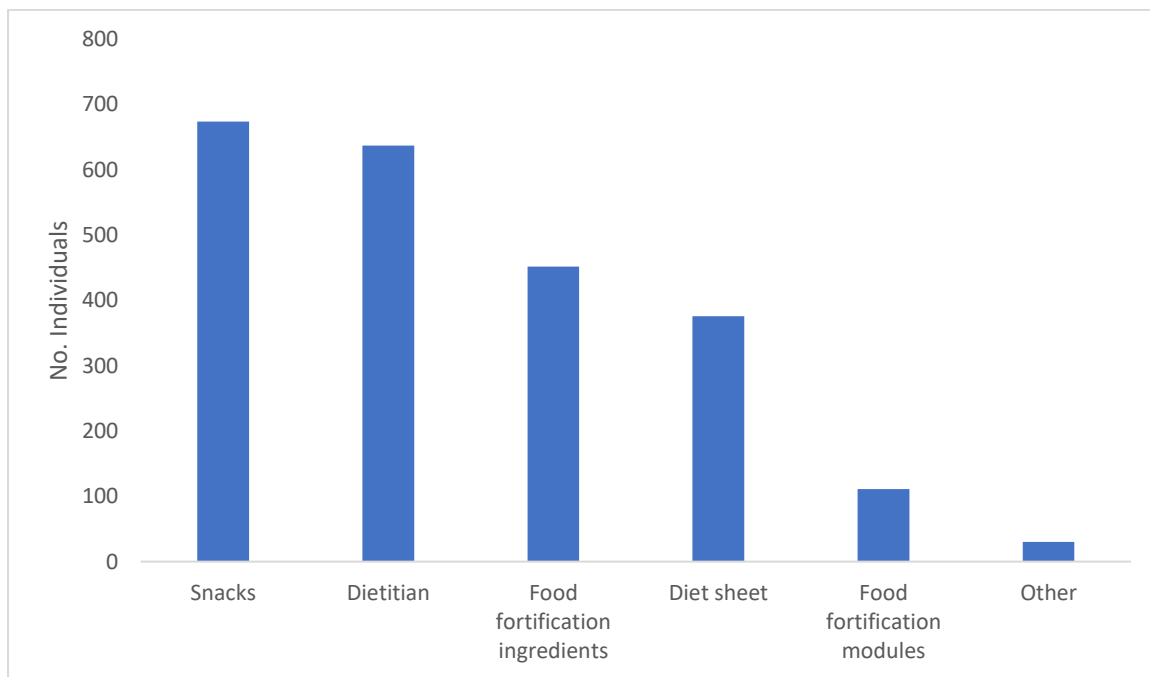
Overall, of those that had a care plan in place (n 1257), most (89%; n 1119) included food-based interventions (snacks, fortified foods with food ingredients, dietary counselling) (Figure 4). Two thirds (66%; n 829) had oral nutritional supplements (ONS) (mostly ready-made liquid ONS of varying energy density, Figure 5) and 41% (n 513) had enteral tube feeding (predominantly continuous feeding regimens with 1-1.5kcal/ml and high protein tube feeds) (Figure 6). Sixty five care plans (5%) included parenteral nutrition. Of note, individuals could have more than one intervention in their care plans.

### Food Based Interventions

Overall, 89% of those that had a nutritional care plan in place received food-based interventions (n 1119). Figure 5 shows that, of those receiving food-based interventions, the most used were snacks and Dietetic input. The use of fortified diets, using food and modules, and diet sheets were also common. 'Other' less

commonly listed components of the care plan included texture modified diets and milky drinks/milk shakes.

**Figure 4: Food based interventions in nutritional care plans for all patients**



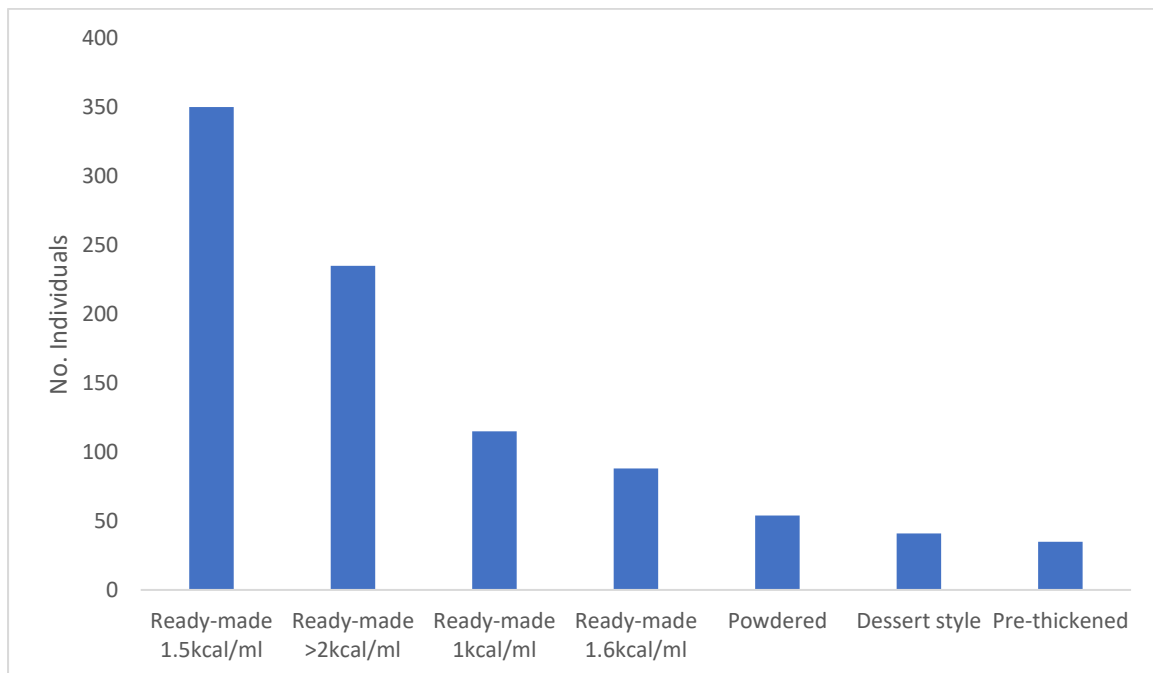
\* Individuals may have had more than one intervention

For those patients at medium (n 162) and high (n 595) malnutrition risk who had a care plan in place, three quarters received at least one food-based intervention.

### Oral nutritional supplements (ONS)

Of those individuals that had a nutritional care plan, 66% received oral nutritional supplements (ONS) (n 829). Of those receiving ONS, ready-made liquid (RML) feeds were most used, with the highest proportion of care plans including 1.5kcal/ml and >2kcal/ml ONS (Figure 6). Other types of ONS included in care plans included lower energy density (1kcal/ml) RML ONS, powdered ONS, dessert style ONS and pre-thickened ONS.

**Figure 5: Oral nutritional supplements in nutritional care plans for all patients**



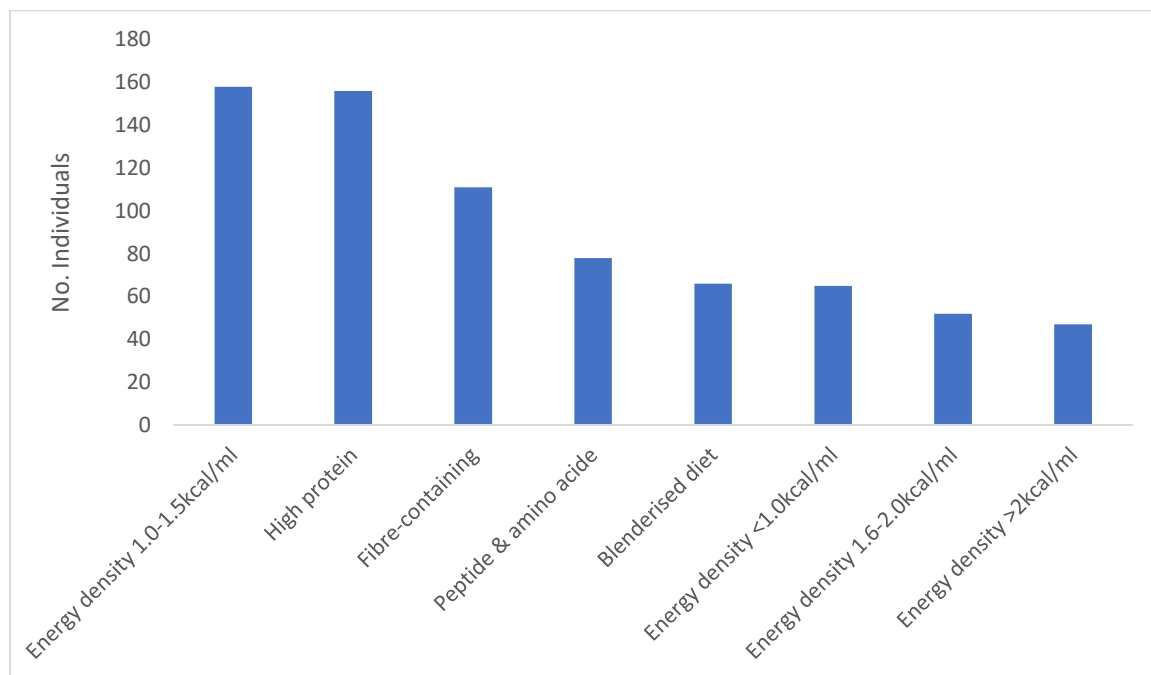
\* Individuals may have had more than one intervention

For those patients at medium (n 162) and high (n 595) malnutrition risk who had a care plan in place, 71% received ONS, which could be alongside other interventions.

### Enteral Tube Feeding and Parenteral Nutrition

Forty one percent (n 513) of patients who had a nutritional care plan had enteral tube feeding included. The most used tube feeds included 1-1.5kcal/ml and high protein tube feeds, although a wide variety of other tube feeds were also recorded, including fibre-containing, peptide/amino acid and use of a blenderised diet. Where it was stated, the regimen involved continuous feeding (n 152) more so than boluses (n 45).

**Figure 6: Enteral tube feeds in nutritional care plans for all patients**



\* individuals may have had more than one intervention

For those patients at medium (n 162) and high (n 595) malnutrition risk who had a care plan in place, 43% received enteral tube feeding, which could be used alongside other interventions.

Overall, sixty-five individuals had parenteral nutrition in their care plan, mostly fed via the central route (n 33).

## Conclusions

This 5<sup>th</sup> BAPEN Malnutrition and Nutritional Care survey, undertaken throughout November 2023, suggests a high prevalence of disease-related malnutrition, identified using 'MUST', across care settings in the UK and the Republic of Ireland. Nearly one half of the individuals in this survey (48%) were at risk of malnutrition using 'MUST', higher than previous surveys (2022 (45%), 2021 (39%), 2020 (40%) and 2019 (42%)) (2-5), a recent survey by IrSPEN in the Republic of Ireland (6) and higher than earlier but larger surveys undertaken by BAPEN in the past (7, 8).

The prevalence of malnutrition was similarly high across the countries and regions that participated in the survey and across hospital and community settings. As in last year's survey (5), whilst around one fifth of patients were



underweight (BMI < 20kg/m<sup>2</sup>), 18% were obese (BMI > 30kg/m<sup>2</sup>) and around one quarter had unplanned weight loss.

Malnutrition prevalence was highest (over 50% of patients) in those with gastrointestinal conditions, cancer, cardiovascular conditions, trauma and orthopaedic conditions and in those with a primary diagnosis of COVID-19. However, in other diagnostic groups, in most cases, over 40% were at risk (neurological conditions, musculoskeletal, frailty, respiratory etc.), indicating the ongoing impact of diseases on nutritional status.

To have a more certain indication of the prevalence of malnutrition (according to diagnosis, setting, country and region), larger sample sizes are needed in future with wider reporting from all health and social care professional groups. It is possible that health care professionals who work in nutritional care are more likely to be aware and participate in the BAPEN survey, and more likely to report individuals with malnutrition and in need of nutritional care. Therefore, the true estimate of malnutrition prevalence in the wider population across care settings, diagnoses, countries and regions may be lower overall but further research is needed to validate this assumption. However, this survey also assessed the use of nutritional care and found that the presence of nutritional care plans overall was quite low (56%) and lower than last year (62% in 2022) (5), almost returning to the levels reported in 2021 (50% of individuals overall)(4). Similarly, a lower proportion of both medium (from 71% to 62%) and high (from 91% to 73%) risk patients had a care plan in place. The reasons for this require investigation but could include fewer resources in clinical practice to oversee or undertake the nutritional management of malnutrition, and lower awareness/prioritisation of nutritional care amongst other clinical tasks.

The use of enteral tube feeding in those that had a care plan in place was higher than previous years (at 43%), which may have been due to the centres participating in the survey this year or a trend towards more enteral feeding in clinical practice. Recorded PN use (n 65 vs. n 79 in 2022) was similar. Overall, the use of food-based interventions had increased in those with care plans (89% had at least one food-based intervention), with snacks and dietetic input the options that were most recorded. Oral nutritional supplements were recorded in 66% of the care plans in place, a small increase compared to last year, with the most used types being ready made liquid ONS (1.5kcal/ml and >2.0kcal/ml) (noting that patients may have had more than one intervention).

As in previous surveys (2-5), individuals at low risk of malnutrition also had nutritional interventions in their care plan, including food-based intervention and all forms of nutritional support. This may be due to the need for nutritional

interventions to maintain nutritional status in individuals, including preventing any future nutritional decline with disease or treatment. However, this survey did not collect data to assess the reasons for specific nutritional care plans, to check the clinical appropriateness of different treatment options or to assess their impact on clinical outcomes and further research would be needed. Nevertheless, a large evidence base, together with national and international guidelines highlight the clinical and economic value of identifying and treating malnutrition appropriately and the costly impact of disease related malnutrition if left untreated (9-15).

It was encouraging to have a larger participation from all four nations in the UK and the Republic of Ireland in this survey (2250 participants) and we hope for even greater participation in future to make sure the malnutrition prevalence data becomes more representative by country, region, setting and diagnostic group. Larger participation will also enable us to build a more accurate picture of the use of nutritional care in different settings, patient groups and in different regions/nations of the UK and assess locally and nationally potential areas for improvement, and where guidance, education and training, or policy change is required.

However, based on the results of this current survey, it appears greater efforts are needed, not only to address such a high prevalence of malnutrition, but to make sure those that are malnourished have a care plan in place, with a view to improving the outcomes of these individuals with timely nutritional intervention, with appropriate use of food interventions and all other forms of nutritional support.

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## Acknowledgements

All of the participating health and social care trusts, professionals and patients.

Data management system, survey portal and data analysis: Rebecca Fagan and Nikki Lawford, Transformation Directorate, NHS South, Central and West.

## Potential conflicts of interest

In addition to their academic affiliation (Faculty of Medicine, University of Southampton), in 2023, Dr Rebecca Stratton (MAG Chair in 2023) and Dr Abbie Cawood (MAG committee member, 2023) were also employees of Danone Specialised Nutrition.

# Appendices

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## APPENDIX A

# Invitation letter to participate in a National Survey of Malnutrition and Nutritional Care



November 2023

Dear Sir/Madam,

**Re: Invitation to participate in the BAPEN survey of malnutrition and nutritional care in association with UK Malnutrition Awareness Week (from 6<sup>th</sup> to 30<sup>th</sup> November 2023)**

Please join BAPEN in undertaking the next survey of malnutrition and nutritional care during the month of November, coinciding in part with Malnutrition Awareness Week (#UKMAW2023).

We are asking individuals working in health and social care to screen for malnutrition using 'MUST' and record any nutritional care a person is given at a point in time during the month of November 2023.

The survey can be undertaken online through a secure link on the BAPEN website: <https://www.bapen.org.uk/malnutrition-overnutrition/combating-malnutrition/uk-malnutrition-awareness-week> for individual professionals and organisations to use. A simple form accessed via the BAPEN website will allow you to quickly and easily input the screening results of each person in your care and information on the nutritional care they receive.

This survey will help us understand the prevalence of malnutrition and use of nutritional care in your local area and nationally across the UK in 2023. There will be a small prize for the top screener from England, Scotland, Wales and N Ireland.

**For more information and to take part, go to the BAPEN website: <https://data.bapen.org.uk/maw/maw-home>**

The reports from previous years surveys can also be found on the BAPEN website.

Wherever you work, please join us in this national initiative and thank you so much for your support.

Yours faithfully,

Dr Rebecca Stratton, Chair, Malnutrition Action Group (MAG)

Dr Trevor Smith, President, British Association for Parenteral and Enteral Nutrition (BAPEN)

BAPEN (British Association for Parenteral and Enteral Nutrition) is a Charitable Association that raises awareness of malnutrition and works to advance the nutritional care of patients and those at risk from malnutrition in the wider community. For more information about BAPEN, and UK MAW week please visit [www.bapen.org.uk](http://www.bapen.org.uk)

## APPENDIX B

### Paper form for the National Survey of Malnutrition and Nutritional Care

Please complete each section and transfer to the electronic portal.

#### Part 1- Background Information

Where does the individual currently reside?

Hospital	
Community Hospital/Rehab Unit	
Own Home	
Care Home	
Mental Health Unit	
Other (Please state)	

Length Of Stay (days) (if applicable)	
Age	
Gender	

Disease category of primary diagnosis (choose 1)

Cancer	
Cardiovascular e.g. CVD,CAD	
COVID-19	
Frailty	
Gastrointestinal e.g. Crohns, Colitis (excluding cancer)	
Genito / Renal	
Musculoskeletal e.g. arthritis	
Neurological e.g. stroke, MND	
Respiratory e.g. COPD, CF	
No disease	
Other (please state)	

#### Part 2 – ‘MUST’ (all calculations of MUST will be automatic when this data is transferred to the portal)

<b>Current Weight</b> <i>(metric or imperial)</i>		
<b>Current Height</b> <i>(metric or imperial)</i>		
<b>Has the individual recently lost weight without trying?</b>	Yes	No
<i>If yes to unintentional weight loss:</i> <b>What was their previous weight or How much weight have they lost over the last 3-6 months (metric or imperial)</b>		
<b>Is the individual acutely ill and has had (or likely to have) no nutritional intake for more than 5 days?</b>	Yes	No

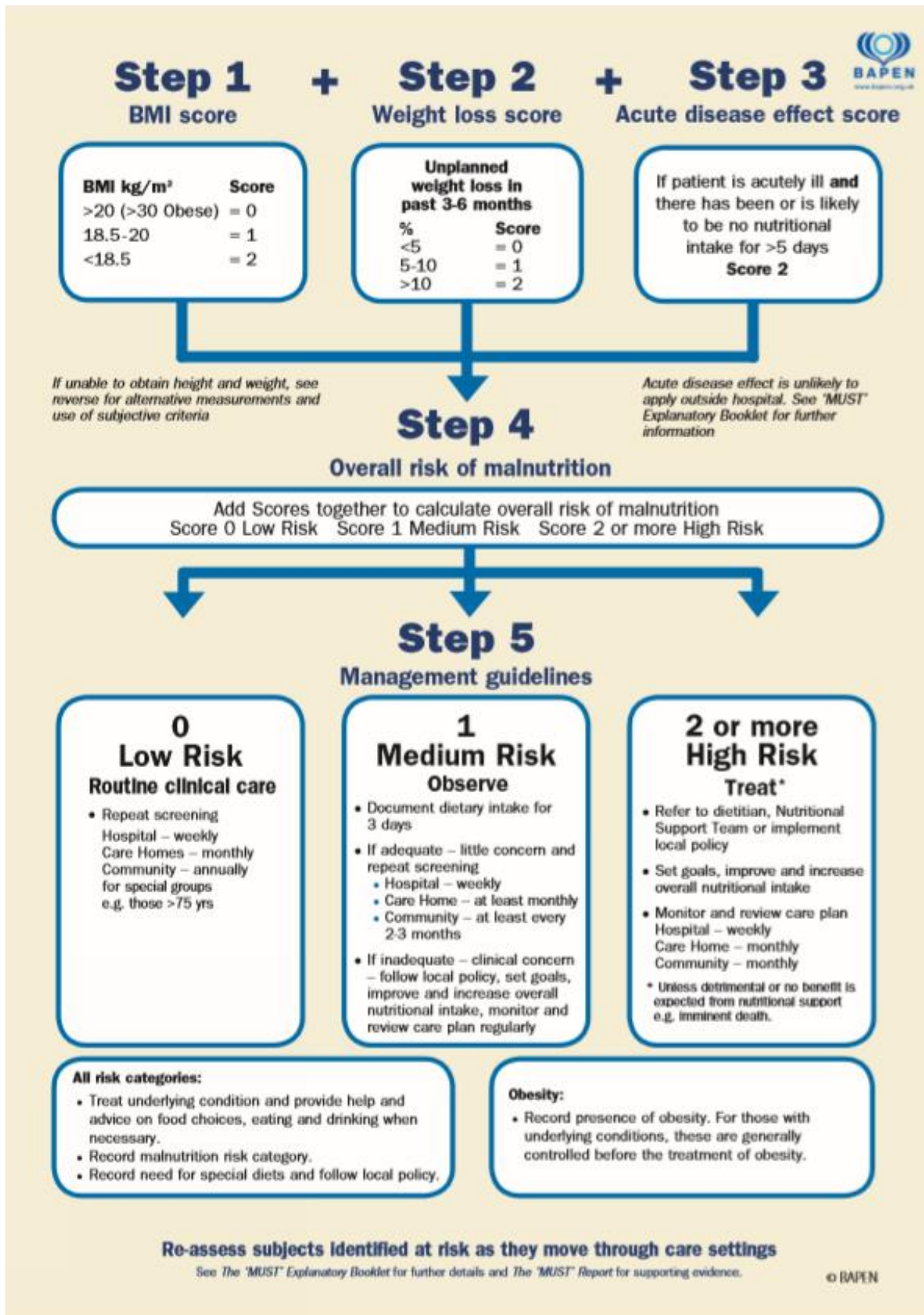
### Part 3 – Malnutrition Management Plan

<b>Is there a care plan in place for the management of malnutrition?</b>	Yes	No
	Other – Please state	
<i>If Yes: please mark all treatment options that apply</i>		
<b>Food based intervention</b>	Snacks Diet sheet Fortified foods with food ingredients Fortified foods with modular feeds Dietary counselling by dietitian Other (please specify)	
<b>Oral nutritional supplements</b>	Ready-made liquid 1.0kcal/ml Ready-made liquid 1.5kcal/ml Ready-made liquid 1.6kcal/ml Ready-made liquid > 2kcal/ml Pre thickened Dessert style Powder Other (please specify)	
<b>Enteral Tube feeding</b>	Continuous Bolus Energy density < 1kcal/ml Energy density 1-1.5kcal/ml Energy density 1.6-2kcal/ml Energy density >2kcal/ml Fibre containing High protein Peptide/amino acid Blenderised diet Other (please specify)	
<b>Parenteral Nutrition</b>	Yes	No
<b>If Yes: Is PN managed by a nutrition support team</b>	Yes	No
<b>Parenteral Nutrition route</b>	Cannula Central Line Peripheral Line Other (please specify)	
<b>Other nutrition support option in care plan</b>		
<b>General comments on screening and management of malnutrition</b>		



## APPENDIX C

'MUST' (see [www.bapen.org.uk](http://www.bapen.org.uk) to download, and for full resources)





**BAPEN**

*Putting patients at the centre  
of good nutritional care*

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