

MINUTES

Malnutrition among Older People in the Community: New Mechanisms for Prevention and Improvement

Time: 14.30pm to 17.30pm, March 21st 2006

Venue: Room 134, 2 Millbank, SW1

This workshop was organised by the European Nutrition for Health Alliance (www.european-nutrition.org), International Longevity Centre UK (www.ilcuk.org.uk) and BAPEN (British Association for Parenteral and Enteral Nutrition) (www.bapen.org.uk), in association with the Parliamentary Food and Health Forum.

In Attendance:

Elaine Cass
Practice Development Manager
Social Care Institute for Excellence

Professor Marinos Elia (*Chair*)
Professor of Clinical Nutrition and Metabolism
Institute of Human Nutrition
Southampton General Hospital

Professor Jacqueline Filkins
Hon. Chairman
European Nurse Directors Association

Baroness Gibson
Parliamentary Food and Health Forum

Simon Goodenough
Director
Upstream Healthy Living Centre

Baroness Sally Greengross
Chief Executive
International Longevity Centre UK

Nicky Hayes
Consultant Nurse for Older People
King's College Hospital

Sue Hawkins
Chair, National Minimum Standards Working Group
National Association of Care Catering

Jon Head

Senior Development Manager
Hanover Housing Association

James Lloyd
Research Coordinator
International Longevity Centre UK

Margaret Lumbers
Project Director
Food in Later Life

Nora MacLeod
Parliamentary Officer
International Longevity Centre UK

Frank de Man
Secretary-General
European Nutrition for Health Alliance

Gary Martin
Deputy Chief Executive
Action on Elder Abuse

Dr Alistair McKinlay
Consultant Physician/Gastroenterologist
Malnutrition Action Group, BAPEN
Grampian NHS Trust

Anne Milne
The Nutrition Society

Claire Milne
Sustain

Tracy Paine
Operations Director, CLS Care Services
Royal College of Nursing

Imogen Parry
Director of Policy, EROSH
Independent Sheltered Housing Consultant

Lord Rea
Chairman
Parliamentary Food and Health Forum

Rhonda Smith
BAPEN (British Association of Parenteral and Enteral Nutrition)

Dr Toni Steer

Nutritionist
MRC Human Nutrition Research

Louisa Stevens
Director of Policy
English Community Care Association

Vera Todorovic
Consultant Dietician in Clinical Nutrition
Bassetlaw Hospital, Worksop

Dr Suzanne Wait
Director of Research
International Longevity Centre UK

Lisa Wilson
Project Manager, Healthy Communities Collaborative Project
Well and Wise Project

Rick Wilson
Council of Europe UK Alliance

Introduction

The meeting began with a presentation by Professor Marinos Elia entitled *Malnutrition in Older People*. A copy of the set of slides used in this presentation is available, and is being circulated with these minutes.

Prevalence of Malnutrition in the community

* Previous studies have found that as many as 50% of hospital in-patients are malnourished. However, the number of people in hospital at any one time is relatively tiny. In effect, around 97% of malnutrition is outside of secondary care in the community, and is therefore beyond the scope of the recent NICE guidelines (launched February 22nd). However, malnutrition in hospitals receives the lion's share of money within the NHS for addressing malnutrition.

* The prevalence of malnutrition increases with age, and it increases in residential/institutional settings. Regional differences are important, and the prevalence/risk of malnutrition is probably higher in the north than the south.

* It is important to realise malnutrition is both a cause and a consequence of disease.

Causes of Malnutrition among Older People in the Community

* An important point is the effect of life transitions, for example, the loss of motivation to cook when someone loses a partner.

* Social desirability is an issue. Older people won't complain about food because they are afraid of losing a service. We have trouble getting feedback from older people

* We need to realise the relationship between mental health and depression.

Ongoing Initiatives

* There is lots of media coverage of negative CSCI reports on meals in care homes. However, 82% of care homes are delivering to standard. Care homes already screen, and are a step ahead of hospitals.

* The FSA are producing guidelines for care-homes. There is a lot of work being done by the BDA at local level, but it is not widely known. The Royal Institute of Public Health has a practical nutrition handbook for care homes.

* It is worth having a look at the National Primary Care Development Team website (www.npdt.org). There are 7 projects in England, looking at widening access to healthy food. They have collected huge amounts of evidence, focusing on more affordable food.

* There are lots of local initiatives which do not have national attention. E.g., projects in sheltered housing, as well as healthy living centres exist. There is an opportunity to use these resources. A great idea is 'shopping clubs'.

* There are initiatives at the retail and planning level, such as food-mapping: in the community, groups assess gaps in the food retail environment. It is an alternative to the kind of work done by local authority planners. We actually listen to older people, rather than simply using electronic planning tools.

* Those projects not requiring formal partnership can kick open the doors, by setting an example.

Evidence Base

- * We have to consider the evidence base, and how much we have. Do we already have enough? We need to act on what we have.
- * We lack research info on what older people want themselves. For example, food supplements work less well in the community setting. How do older people feel about receiving food supplements? Do they need help with shopping? We need more research.
- * Key question: What kind of evidence is needed to guide decisions?

Awareness Building

- * Following the NICE guidelines, we need to improve awareness of malnutrition among health and social care workers, and the public. Many people still think malnutrition is a natural part of the ageing process. The public thinks it is natural to get thin. This needs to change.
- * One of the biggest problems in the community is the lack of recognition and understanding from families of the signs and incidence of malnutrition among older people. They are often unaware of malnutrition, and therefore do not raise their concerns about relatives with doctors. Education and training are required.
- * Complexity is a problem - malnutrition is not recognised, even by caring people, unless you give them tools and compulsion. For example, nurses will embrace dealing with malnutrition, if they are given the opportunity and resources to do so.
- * We need to improve the awareness of malnutrition and remove the stigma attached to it. Education needs to be part of the solution.
- * Key question: Whose role is it to communicate messages?
- * Key question: How can malnutrition be put on the public health agenda?

Screening tools

- * We need a national screening tool that is user friendly. Just as there are simple tools for detecting cancer, we need a simple detection tool for malnutrition.
- * If a screening tool is used, there needs to be continuity with healthcare provision. Screening and detection must be linked in to a mechanism for treatment.
- * We have little experience of the use of a malnutrition detection tool in the UK, such as MUST (Malnutrition Universal Screening Tool). We need to trial it. We don't want to inundate the health system with people who think they are malnourished. It needs evaluation.

The Role of Sheltered Housing

- * Over half a million people live in sheltered housing. More older people live in sheltered housing, than in care homes. However, there is a lack of awareness of sheltered housing.
- * Sheltered housing could be very important and have huge potential in addressing malnutrition among older people in the community. For example, many sheltered housing schemes have shops on site. Many have facilities that could be used to inform older people about malnutrition.
- * There is a lack of joined-up working with health professionals. All sheltered housing scheme managers have to give an assessment of need to people entering

sheltered housing - this could/should include nutrition and health. Sheltered housing can provide a venue for health promotion and detection of malnutrition.

Training

- * The Royal College of Nursing are adapting their curriculum in regard of malnutrition.
- * More training is needed in clinical settings. The lack of skills amongst auxiliary staff, needs addressing. Cooks also need to be trained.
- * Skills training is needed for community support, for those providing meals etc.
- * We need a course that people recognise, i.e., which has proper accreditation. Ideally, many organisations involved with older people could be required to have someone with this skill on staff, similar to health and safety regulations.
- * Key question: Should education of professionals be pre or post-registration?
- * Key question: Although training is a good idea, the question is: budget? How will it be paid for?

Responsibility for Malnutrition

- * Key Question: Someone has to take responsibility for malnutrition. But who?

Regulation

- * Malnutrition may occur on its own, or may be associated with illness. However, there is too little interest at the primary care level. Malnutrition needs to be included in the QOF (Quality and Outcomes Framework) for GPs.
- * We need to clear up confusion caused by NICE guidance. Care homes are confused about who they should listen to – NICE or CSCI, which already include nutrition. Greater clarity is needed
- * We need regulations imposed, so that we can track people suffering malnutrition. For example, when people leave hospital with malnutrition, we must discharge them with a diagnosis of malnutrition, so that they can be followed up by the health system, and there is a requirement to do so.
- * We need mandatory requirements on screening, delivery of meals, information for families and carers.
- * It is important to give consideration to the guidelines produced by the various Royal Colleges.
- * We have a problem engaging domiciliary care. We need to be more prescriptive in this area. We need to engage professionals.
- * We need to include the regulators in addressing this problem.
- * Malnutrition is not really spelled out in any of the NSFs.

Community-level Implementation

- * Lots of organisations share the responsibility for addressing malnutrition in the community. The challenge is how complex the problem is. There are so many different stakeholders, and not enough resources. How to tackle that? It needs to be cross-sectoral, e.g., local area agreements; local food retail strategies. There is no one-size fits all strategy.

- * There is a need for joined up health and social care. Voluntary sector needs to be in the same room as the statutory sector.
- * How can we break the cycle of going into hospital? We need to use social care professionals and VCOs – they could trigger a SAP. Standards of social care are important.
- * We need statutory obligations for partnership. ODPM has role to play.
- * We need champions at a local level.
- * Many care workers are just too rushed to ensure that people are eating properly, or to prepare nutritious food for them.
- * For example, in the past, geriatric health visitors were enormously effective. We need a replacement for them.
- * There can be problems getting GPs involved. We need to tell people to work in partnership.
- * We need to get local service agreements undertaken locally. For example, where voluntary and community organisations are ‘quality-assured’, as is the case with some Healthy Living Centre, this enables GPs to access them. It is possible to get VCO representatives on to GP committees.
- * We could piggyback on the Sure Start for older people to improve malnutrition.
- * Healthy Living Centres could take on more of a role in addressing malnutrition.
- * Key question: Who should have responsibility for detection? Social care? Home care?

Other issues

- * We also need to recognise cultural diversity in diets.
- * Meals on wheels – local authorities are putting up the prices. There is a debate involving Meals on Wheels that is important to consider: some people believe Meals on Wheels should not provide regular meals as this creates dependency.
- * At the EU level, the Green Paper gives little space to malnutrition, and focuses on obesity. This shows it is not on the agenda. Malnutrition is not recognised because it is so complex.
- * IT is an issue worth mentioning. Many care homes don’t have access to the internet.
- * Any initiative has to find a balance between maintains independence.
- * Key question: Choice - how do we deal with people who choose to eat chocolate bars all day?
- * Key question: We have to think about the ‘point of contact’, and how to get to grips with a diverse population. What is the point of contact for a diverse population?

Next Steps

On the basis of these discussions, the European Nutrition for Health Alliance, BAPEN and the International Longevity Centre UK will be launching a policy report in the House of Lords.

A draft copy of this report will be circulated to all participants of this workshop for comments and feedback.

The report will be launched on May 17th in the Strangers’ Dining Room, House of Lords. The launch will be for all relevant stakeholders, parliamentarians and media.

For more information, please contact:

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