



ASSOCIATE PARLIAMENTARY FOOD & HEALTH FORUM



Nutrition, malnutrition and elderly people

5-6.30pm, Tuesday 20 March 2007

HC Committee Room 8

Lord Rea welcomed members to the meeting and introduced the two guest speakers: Dr Suzanne Wait, the Research Director of the International Longevity Centre-UK and Dr Clive Bowman, Medical Director of BUPA Care Services. Lord Rea noted that the issue of malnutrition among older people has risen up the political agenda, with the announcement by the Government on 14 March that a “National Action Plan” was being developed to tackle the issue of older people and nutrition.

Dr Clive Bowman

Clive Bowman is the Medical Director of BUPA Care Services. Previously Clive was a Consultant Physician for 15 years and had an academic appointment at the University of Bristol. He is also the Chairman of CCC (previously known as the Continuing Care Conference), a broad-based coalition of organisations with a shared interest in improving the care of older people in the UK.

Clive Bowman said that nutrition in care homes was raised with him during his working life largely when people are disappointed with the nutritional support which members of their family have had in care homes. It often becomes apparent that their expectations are unrealistic.

People are living longer – the average lifespan of a man is now over 80 years and it is longer for women. That longevity is partly the result of people feeding themselves well throughout their lives. Clive Bowman showed members two photographs: one showing robust young women from a workhouse in Leeds from the turn of the century; and another dating from 1959 showing men in care having tea in a former workhouse. None of these people looked under-nourished. He then read an extract from Alan Bennett’s book, “Untold Stories” which had been serialised in a Sunday paper in 2005 under the heading, “The Candlewick Way of Death”.

“The turnover of residents is quite rapid since whoever is quartered in this room is generally in the later stages of dementia. But that is not what they die of. None of these lost women can feed herself and to feed them properly, to spoon in sufficient mince and mashed carrot topped off with rhubarb and custard to keep them going, demands the personal attention of a helper, in effect one helper per person. Lacking such one-to-one care, these helpless creatures slowly and quite respectably starve to death. This is not something anybody acknowledges, not the matron or the relatives (if, as is rare, they visit), and not the doctor who makes out the death certificates. But it is so.”

Clive said he couldn’t compete with Alan Bennett’s prose, but he questioned whether the quality of life of the people described by Bennett would be different if they were fed differently – he suggested that would not often be the case.

Clive then read an extract from a submission in the BMJ online 2006 written by Dr Ansell, a senior lecturer in the Department of Health at York University.

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Vice-Chairmen: Dr Ian Gibson MP
& Baroness Miller of Chilthorne Domer
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“Significant weight loss marked the beginning of the end of their lives for each of my long-lived parents and parents-in-law (three of whom had dementia), but once we were able to accept this and stopped trying to ‘feed them up’ food ceased to be such a worry. They each developed idiosyncratic tastes and my late father happily ate a doughnut a day but almost nothing else for several years. My mother, now in her 90th year, eats only toast, spicy rice dishes and jelly babies. To her relief we have finally stopped trying to persuade her to vary her diet and my brother and I now cook and freeze small quantities of what she likes to eat. With this bespoke meals service my very frail mother continues to live alone in her own home and appears to be meeting her nutritional needs.”

Clive then showed some photographs of people in BUPA care homes taken in 2006, which showed older people in natural, domestic settings. There was nothing in the photograph to indicate why these old people were in care – they were dressed normally and looked healthy. Clive suggested this was a tribute to the quality of care they received.

Last year, CCC had undertaken a survey of 30,000 people living in care homes with the support of BUPA Care Homes, members of the Registered Nursing Homes Association (small providers), the National Care Forum and the Cornwall Registered Homes Action Group. 751 homes responded; 32,301 residents returned out of population of 40,843 - a return of 79%. The census found that the average age of residents in care is 83.6 years and 93.7% of residents were in long term care. 71% of residents were state funded, while 29% were self funded.

Social need is not the main cause for people moving into care homes. Only 11% of care home residents had no obvious clinical reason for entering a care home. Of the reasons for entering residential care, 54% of residents’ decisions related to dementia, stroke or Parkinsonism; 86% of residents had one or two diagnoses driving their need for care; and 24% of residents were confused and immobile and incontinent. It is clear, therefore, that most care home residents have chronic health conditions and many have significant disabilities.

Clive referred to the Axbridge Union Workhouse, which was erected in 1837 and referred to rules for the inmates which stated that residents should not be served salmon (then a common and cheap food) more than four times a week! He described a cadre of retired Somerset farm-workers in care, he had known early in his career. These men were used to eating “meat & two veg” at their meals, which were served by a local cook. The local Health Authority decided, however, to replace the cook with a chilled meals service which provided dishes such as individual pizzas and vegetarian curries. They did not like the new diet, though it was nutritionally adequate, and simply did not want to eat it. Clive, recognising the importance of ensuring that meals offered to residents should reflect their preferences, succeeded in having the chilled meals service withdrawn.

A report was published in 1998 about nutrition in NHS hospital wards, entitled “Dignity on the Ward”. The practice at that time if people could not eat properly - for example as a result of a major stroke - was to ensure that feeding tubes were inserted into the patients without delay to avoid the risk of malnutrition. This led to problems, however, as hospital wards filled with older people who might be unconscious or semi-conscious, but who could not benefit from the acute services a large hospital could provide. These patients were discharged from hospital to care homes where they continued to be well nursed and well nourished but where nothing could otherwise be done to improve their condition. Clive noted that not only was this very distressing for their families it did little to advance the individuals’ dignity, he questioned whether it was a sensible use of public funds.

Clive referred to a NICE report published in 2006, which recommended the wishes of patients should be respected where they had the capacity to make decisions and otherwise act in the best interests of residents, but Clive questioned whether it was appropriate for care home staff to assume this responsibility. Decisions on nutritional support can be difficult and residents and members of their families may hold differing views.

The NICE report attracted a great deal of media attention. At the same time Clive was dealing with adverse media comment about food served to residents in a BUPA care home. While the fresh fruit offered to residents was commended by the journalist who wrote the article, she objected to the “lime green jelly” they were also offered.

Clive emphasised that for people in long-term care, the care home is their home and their food preferences should be taken into account. BUPA strives to ensure that the food provided in their homes is of good quality and attractive to residents. It has competitions for BUPA chefs and runs a Chefs Forum so they can meet to exchange information and menus. BUPA has introduced “quiet times” at mealtimes, so that residents – particularly those with dementia – are not distracted. People with early dementia can be very active, so BUPA has introduced “light bites” and “night bites” so that these residents can eat when they are hungry around the clock. BUPA has also introduced guidelines and practical equipment – such as stools for staff to sit on when they are helping residents to eat – to ensure that residents can be helped in a manner with which they are comfortable.

In addition BUPA also takes part in serious research. It has participated in a study run by the Wolfson Institute and Southampton University, which involved 3500 residents over a long period. No evidence was found to demonstrate that consumption of vitamin D supplements had a positive effect on the number of fractures these residents sustained. However in spite of a careful study design it may be that a higher dose vitamin D supplement may have a positive effect, getting evidence can be difficult!

Clive summed up by making three key points: nutrition is more than a matter of food and feeding; accelerated weight loss may signal the transition for a person from living with a chronic disease to the onset of a terminal decline; and a greater understanding of the limits to nutritional support in advanced life is required both among the public and health professionals.

Baroness Gibson asked how much importance is attached by care homes to the views of relatives about members of their family who are care home residents. **Clive** said if the resident has capacity then his/her views are paramount, but if the resident lacks capacity the views of relatives would be taken into account. However, difficulties can arise when families do not have a consolidated view.

Dr Suzanne Wait

Suzanne Wait joined the ILC-UK as Director of Research in January 2004. She is a Senior Research Fellow at UCL at the School of Public Policy. She also runs a consultancy (SHW Health) which provides health policy and health outcomes advice to private and public sector clients.

Suzanne explained that the International Longevity Centre UK (ILC-UK) is working as part of the European Nutrition for Health Alliance (ENHA) to put malnutrition on the European political agenda and to advance policy in terms of nutrition. She acknowledged that this issue is receiving increasing attention in the UK, but even in the UK vastly more political and public attention is given to obesity. However, the economic burden of malnutrition is equivalent if not greater than that of obesity at £7.3 billion per year. Suzanne suggested the causes and consequences of poor nutrition are clinical, social and psychological.

The ENHA is an alliance of key European stakeholders in the fields of nutrition, health and social care and policy (ESPEN, HOPE, ENDA, AIM et al) which provides a network for reaching target groups at EU and national levels. The ENHA’s common objective is to raise awareness of the urgent need to prevent malnutrition and ensure that effective nutritional support is available to all those affected across all community and clinical settings. Their goals are to achieve recognition of malnutrition as a condition in the EU which is preventable, treatable, and curable; recognition that malnutrition is a huge social issue, occurring ‘through no malice or cruelty’ (A. Bennett); and to encourage stakeholders to accept responsibility and take action.

Malnutrition is an issue, like mental health, where an integrated approach is necessary. The big issue is who should take responsibility for tackling it.

Last March, the ILC with the support of the ENHA, the Associate Parliamentary Food and Health Forum (FHF), the British Association for Parenteral and Enteral Nutrition (BAPEN), voluntary sector groups, academics and medical professionals held a workshop to identify the key malnutrition issues and discuss how it could best be tackled in the community. They found that malnutrition is often forgotten in existing guidance and policy and that it is often unrecognised, undetected and under-treated. This workshop resulted in a “call for action” that was launched at the House of Commons, with the support of the FHF, in May 2006.

Professor Marinos Elias, who acted as the facilitator at the March workshop, demonstrated the complexity of the problem and the difficulty of finding solutions. He used a diagram (see slide 12 attached) to illustrate four groups of factors he had identified which contributed to malnutrition: poverty, functional constraints, mobility and psychological factors. Suzanne acknowledged that clinical factors were not identified on the diagram, but should have been.

The call for action which was produced following the workshop highlighted some key issues, including the need to: incorporate malnutrition into the public health agenda; adopt an inter-sectoral approach; raise awareness of malnutrition amongst older people, their families and the public at large; incorporate access to nutritious food into local and community planning; develop adapted and accredited training in nutrition for all health, social care professionals and associated personnel; find viable ways to screen for malnutrition in the community and define standards and pathways of care. Suzanne emphasised the need for food mapping and screening, pointing out that some tools have been identified, but it is still not apparent who should be responsible for screening for malnutrition in the community and who should follow through with appropriate care pathways.

Screening in the community is necessary, but many older people do not have regular contact with their GPs. Even if they did have regular contact with them, GPs are not adequately trained in nutrition and the amount of time they have with individual patients is limited. A European survey (SHARE) found that less than 50% of GPs weighed their older patients on a regular basis.

Suzanne suggested that social workers, managers of sheltered housing schemes and informal carers could be involved in more creative outreach programmes to screen for malnutrition among older people in the community, but they too would need training.

At a European level, the ENHA is calling for a move from malnutrition to “wellnutrition”. They issued a call for action in November 2006 which argued that malnutrition should be on the political agenda across the EU; professionals need to be better held to account if the prevention of malnutrition is to become a core pillar of care; and innovative models are needed to ensure that good nutrition is fully integrated into all aspects of care delivery. This will necessarily involve appropriate training, recognised standards of care and accreditation – none of which will be easy to implement. Suzanne suggested that in the UK we have reached an exciting point in terms of recognition of the problem of malnutrition, particularly among older people, and the need to tackle it.

Questions and comments

Baroness Miller suggested that malnutrition outside care homes is, possibly, the most worrying problem because it is less measured and responsibility for dealing with it is less clear cut. **Suzanne** agreed and said the problem was very localised – with huge variation from area to area. She suggested that possibly the most appropriate person to take responsibility for malnutrition in the community is the District Nurse, but that assumes they have sufficient time and resources to undertake outreach work. **Clive** suggested the key issue is changes in a person’s weight – some people are naturally thinner or fatter, but if they were otherwise fit and healthy he would not be

concerned. It is when a person's weight changes for no obvious reason that one should be concerned. When people go into a BUPA Care Home they are screened, staff will assess their condition and consider whether anything can be done to improve it.

Baroness Greengross suggested health visitors would be the ideal people to take responsibility for malnutrition in the community, but they currently focus on young children (under 5) and in any case they have huge workloads. An alternative would be to train the people who deliver meals on wheels to identify malnutrition in the community. She also suggested that dehydration was a problem that needed to be considered.

Clive suggested that the general nutritional status of the population people was much healthier than forty years ago, when as a young doctor he had encountered cases of scurvy and rickets, which were virtually unknown now. Whilst he recognised the value of the health visitor role he thought a wide range of health professionals and social workers should be able to identify those older people at risk of malnutrition.

Lucy Wilson of Sustain said they were trying to raise awareness of the issue of food access, where difficulties arose for a number of reasons ranging from inadequate information, to mobility problems and social factors, such as bereavement. She also explained the difficulties that can arise in obtaining feedback from people in care homes who may be reluctant to criticise food or arrangements for meals.

Jenny Lisle of the Royal College of Physicians, Faculty of Public Health, suggested the older people most at risk of malnutrition in the community should be identified so that a policy could be developed to prevent this risk. She also referred to the practice in hospitals and care homes of completing a daily report on each patient/resident and suggested that their nutritional status and whether the person has eaten should be included in this report. **Suzanne** said one of the ENHA recommendations was that people leaving hospitals or care homes should be discharged with information about their nutritional status and recommendations for their support. **Clive** agreed that sharing information and continuity of clinical leadership is crucial, but staff turnover could jeopardise this. Staff turnover in care homes has decreased over the last five years, but he thought this could still be a problem in NHS hospitals.

Baroness Masham of Ilton agreed that staff turnover and the failure to share information about individual patients between staff going on and off duty could lead to unsatisfactory treatment in NHS hospitals. She also reported criticism of the food served in NHS hospitals and cited Stoke Mandeville Hospital as an example where patients relied on takeaway meals to supplement their diet. She suggested families and volunteers could be used to help patients eat their meals, but recognised that this would need to be organised. **Clive** described the positive benefits that could be achieved when care home staff were trained in the needs of particular groups of patients, such as people suffering from Parkinson's Disease.

Ben Lewis from Paul Burstow MP's office asked how staff in care homes could be trained to recognise the difference between a patient losing weight as a result of malnutrition and one losing weight as a result of clinical factors. **Clive** said that screening on admission, adequate training and knowledge of a resident's clinical condition could help, but sometimes the difference only becomes clear retrospectively. He emphasised the need for a single assessment process so that consistent standards could be achieved.

Christine Hunt of Age Concern asked how residents' cultural or ethnic food preferences could be taken into account in care homes. **Suzanne** referred to research the ILC is carrying out with the support of Bupa Care Homes and in partnership with CCC on this issue. **Clive** said many care homes reflect their local communities both in terms of residents and staff, including the chefs, so the provision of, for example, kosher or halal food could be achieved in response to local demand.

Baroness Gibson highlighted the need to recognise that food preferences changed over time so that older people might stop eating food they had previously enjoyed.

Baroness Greengross commended menu planning tools developed by the National Association of Care Catering. **Clive** said BUPA Care Homes had used such menu cards for four years, but they also used customer satisfaction surveys and measured the food that was not eaten by residents to ensure that their residents were content.

Conclusion

Baroness Gibson, who had chaired the discussion following the speakers' presentations, thanked both speakers for their very informative speeches, which had inspired a lively debate.

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