



Malnutrition Task Force
Eating and drinking well in later life

State of the Nation 2021

Older people and malnutrition in the UK today

Revised 8/21



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Of the 11.6 million older people in the UK, over a million are estimated to be malnourished or at risk of malnutrition.^{1, 2}

Introduction

Malnutrition is something more readily associated with extreme poverty, usually in countries a long way away from the UK. Many of us would be shocked to find out that our older friends and relatives are also at risk. Yet, this is precisely the case.

It is estimated that around one in ten people over the age of 65 are malnourished or at risk of malnutrition. Malnutrition is both a cause and a consequence of ill health and is a silent and, all too often, hidden problem. It will affect health and wellbeing, increasing hospital admissions, and can lead to long-term health problems for otherwise healthy and independent older people.

Of the 11.6 million older people in the UK, over a million are estimated to be malnourished or at risk of malnutrition.^{1, 2}

Why is this happening? Unfortunately, despite excellent guidance and awareness raising,^{3, 4, 5} awareness of malnutrition amongst older people, their families and many health and care professionals remains low. The risk factors that can contribute to malnutrition remain. There is also patchy availability of care and support services to prevent malnutrition, or identify and treat it when it occurs.

The myth perpetuates that it is 'normal' to get thin as you get older, associated with outdated perceptions that becoming frail is all but inevitable in later life. This is not helped by health messages and public health policy that are preoccupied by reducing levels of obesity, so that weight loss is seen as desirable. There is little recognition that widely publicised advice about diet and nutrition is often unsuitable for older or more vulnerable members of society.

Yet malnutrition is largely preventable and treatable, other than when it accompanies a serious illness like cancer, in which case highly specialist support is required. Because of its widespread prevalence, reducing incidences of malnutrition are associated with large potential cost savings across the NHS and social care.⁶

There are many examples of good practice with

teams up and down the country making real progress on tackling malnutrition, however efforts are patchy and access to help remains a postcode lottery for older people and their families. We urgently need to invest in a proper joined-up strategy, bringing together health, social care and the voluntary sector, to ensure all older people get the support they need.

We also need to look to the future. The UK population is ageing; there are now more people in the UK aged over 60 than under 18.⁷ Furthermore, the next 20 years will see a huge increase in the 'oldest' old; indeed the number of people aged 85 and over is projected to increase by 113.9% from 1.3 million to just under 2.8 million by 2035/36.⁸

The fact that so many people are living into late old age is a real cause for celebration, however it also means that, if nothing changes, there will be many more older people at risk of malnutrition. Living longer means little if it's not living well.

In this report we aim to shine a light on the scale of the challenge of malnutrition in later life. We have brought together information and evidence from across the system to provide a unique snapshot of what is happening to older people who are malnourished or at risk of malnutrition in England.

We examine the causes and consequences as well as costs and associated pressures and ask to what degree the NHS and social care services are currently able to support older people at risk and how invested they are in this issue. Is the system addressing the need?

Understanding malnutrition in later life

What is malnutrition?

Malnutrition, which literally means poor or bad nutrition, can refer to a range of issues, but for many older people it is characterised by low body weight or weight loss, meaning simply that some older people are not eating well enough to maintain their health and wellbeing.⁹

The National Institute for Health and Care Excellence defines a person as being malnourished if they have:¹⁰

- ✦ A body mass index (BMI) of less than 18.5 kg/m².
- ✦ Unintentional weight loss greater than 10% within the past three to six months.
- ✦ A BMI of less than 20 kg/m² and unintentional weight loss greater than 5% within the past three to six months.

We also know that people can become malnourished if they don't eat enough for two to three days as the physiological effects can start very quickly. This means that people quickly experience the adverse effects.

This weight loss is usually unintentional and often goes unrecognised until malnutrition starts to seriously undermine someone's health and wellbeing. It can happen for a wide variety of reasons, often there are multiple causes and every individual's story is unique.

However the reality is that far too many of us, as well as families and professionals, simply accept weight loss and associated poor health as an inevitable part of ageing. As a result, malnutrition too often isn't recognised or addressed until after it has started to adversely affect someone's health and independence.

**2-5
DAYS**

People can become malnourished if they don't eat enough for two to five days. - *add reference*

Why do we become malnourished?

The reasons why a person becomes malnourished can be split into three main categories: medical (or disease-related), physical and social risk factors.



Medical risks

Medical or disease-related risk factors are ones directly related to another on-going health condition. On occasion, malnutrition is a consequence of a particular disease (for example cancer or chronic liver disease). However, malnutrition is often a side effect of the condition or medication, and can be prevented or treated with proper care and support. These include: ill health where the condition, or medication, leads to a reduction in appetite, nausea or weight loss; conditions that affect the digestive system, such as Crohn's disease; long-term conditions such as dementia, cancer and chronic obstructive pulmonary disease (COPD) that make it difficult to eat; or mechanical problems such as dysphagia (swallowing difficulties).



Physical risks

Physical or disability-related risk factors can occur for many reasons and may be related to underlying health problems or a more specific physical difficulty. Dentition is a major factor linked to malnutrition in older people as pain, loose teeth or denture problems can prevent people eating well.¹¹ More obvious physical influences on nutritional health include conditions, such as arthritis, and disabilities, such as sight loss or limited mobility, that make it difficult for someone to get to the shops, prepare and cook food or eat independently.

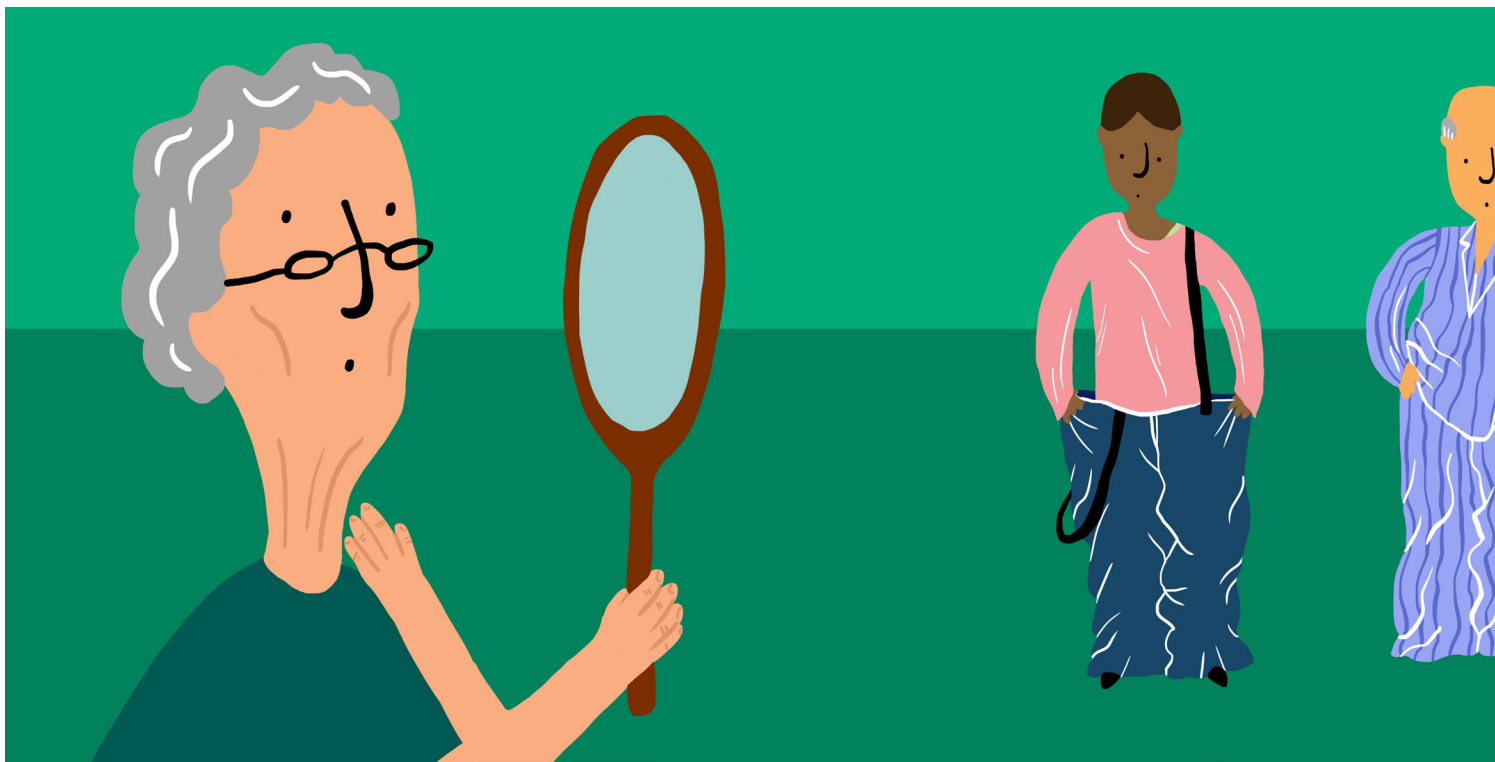


Social risks

Social risk factors linked to malnutrition are often the most complex and range from practical constraints to people's interest in food and motivation to eat well. These include living on a low income, the ability to cook nutritious meals, acquiring a caring responsibility, understanding or attitudes around weight loss and nutrition, bereavement, social isolation and loneliness.

The causes and consequences of malnutrition are often interlinked and, in some cases, develop into a vicious circle. Someone who becomes malnourished will be at greater risk of ill health and injury, which in turn may make it more difficult to eat well. For example, a fall may further reduce mobility and diminish their ability or motivation to eat and drink.

Likewise, being diagnosed with a condition or a disability may impact on mental wellbeing or ability to carry out everyday tasks. These become risk factors for malnutrition even if the condition itself is not. For example, people living with long-term health conditions are two to three times more likely to experience mental health problems,¹² particularly anxiety and depression, which in turn are risk factors for becoming malnourished.



How to spot the signs of malnutrition?

The most obvious sign of malnutrition is unexpected weight loss. This may be gradual or sudden, as a result of an illness, or just unexplained. There are other more subtle signs to look out for such as loose clothing, dentures and jewellery.

Warning signs of increased risk could include:

- Recent ill health or diagnosis.
- A recent hospital stay.
- Problems with oral health or dentures.
- Difficulties in swallowing.
- Practical difficulties with cooking or shopping.
- Change in personal circumstance, such as bereavement or becoming depressed.
- Loss of interest in food, eating a restricted diet, loss of appetite or even not eating.



BAPEN has calculated that older people are disproportionately represented in malnourished groups.



How widespread is malnutrition?

Unfortunately, there are some significant gaps in the data. Despite nationally validated screening tools, the information is not universally collected or nationally collated. This causes a barrier to understanding how and when older people become malnourished.

Much of the data available on malnutrition in later life comes through screening on admission to hospital. The type and quality of data available can vary from one hospital to another and will depend greatly on the investment and knowledge of staff.

Nonetheless it can still prove useful in providing insight into the extent of malnutrition and provide clues to the prevalence of malnutrition in the community as most people are admitted from their own home.

The British Association of Parenteral and Enteral Nutrition (BAPEN) has conducted a number of annual surveys in hospitals, care homes and the community across England, providing information on the extent of malnutrition and the impact of management and treatment.

Based on these surveys, BAPEN have calculated that around one in ten, or 1.3 million, older people are malnourished or at risk of malnutrition, and that older people are disproportionately represented in malnourished groups.¹³

However, in reality numbers could be higher. Most

older people become malnourished in their own homes and, in many cases, the problem is never acknowledged or addressed.

Indeed, research suggests that people living in their own homes who express a lower perceived health or quality of life are at greater risk of malnutrition¹⁴ whether it is formally identified or not.

It is clear more information is needed to fill the gaps in our knowledge on malnutrition in the community, particularly among housebound older people including those who are hard-to-reach or are more isolated.

Impact on older people

In a society more used to worrying about the health effects of obesity, it is easy to overlook how serious malnutrition can be for older or more vulnerable people.

For those in later life, being under nourished can have complex health repercussions and seriously affect health and wellbeing. Malnutrition is associated with several long-term conditions such as dysphagia (swallowing problems), cancer, chronic obstructive pulmonary disease (COPD), dementia and physical disability. It can lead to a weaker immune system, increasing the risk of infections, poor wound healing, and muscle weakness, which can result in falls and fractures.

There are social factors which can contribute to malnourishment, such as bereavement, loneliness and isolation. Malnutrition can also have a negative impact on someone's quality of life because being under nourished is likely to leave them with low energy levels, dizziness and generally feeling under the weather.

For an older person experiencing malnutrition, we know that compared to well-nourished individuals they are:

- ✦ Twice as likely to visit their GP,
- ✦ Have more hospital admissions,
- ✦ Stay in hospital longer,
- ✦ Have more ill health (co-morbidities).¹⁵

However, sadly, research has also found that malnutrition is too often overlooked as an underlying cause of poor health, meaning that an older person can miss out on the appropriate treatment and support.

While this report focuses on malnutrition, it is important to note that dehydration is an equally significant issue. There is little data on the reach and extent of dehydration. It appears to be widespread among older people and is one of the most common reasons why an older person is admitted to hospital.¹⁶ It has also been found to be associated with falls.

Costs to the system

We know that malnutrition leads to an increased demand for support in acute NHS, community NHS and social care services. The latest cost analysis by BAPEN estimates that the cost of malnutrition to the health and social care systems was around £19.6 billion in England in 2011–12.¹⁷

The analysis by BAPEN found that:

- ✦ Treating someone who is malnourished is two to three times more expensive than for someone who is not malnourished.
- ✦ Estimated health and social care expenditure per capita of the population is £2,417.
- ✦ For those malnourished or at risk, the expenditure rises to £7,408 per person in the population.¹⁸

However, there is significant evidence that costs are reduced overall when malnutrition is treated or prevented altogether. BAPEN undertook analysis of several interventions to treat or prevent malnutrition and found that all of them produced net cost savings. This was considered to be more likely under certain circumstances, for example, in areas where prevalence of malnutrition is high, where the rate of hospital admissions is high and when there is a large gap between current levels of care compared to ideal levels of care.¹⁹

£

Treating someone who is malnourished is 2–3 times more expensive than for someone who is not malnourished.

Future trends

It is widely understood that our older population is rapidly ageing. Moreover, it is the oldest part of our population, those aged over 85, which is rising the most rapidly – and it is they who are most likely to be at risk of malnutrition.

Over the next 20 years (2015 to 2035), the number of people aged over 65 is projected to grow by 4.75 million, an increase of just under 50%. At the same time the number aged over 85 is projected to grow by 113.9%, from 1.3 to just under 2.8 million.²⁰ The total number of centenarians is projected to rise from 13,000 to 50,000.²¹

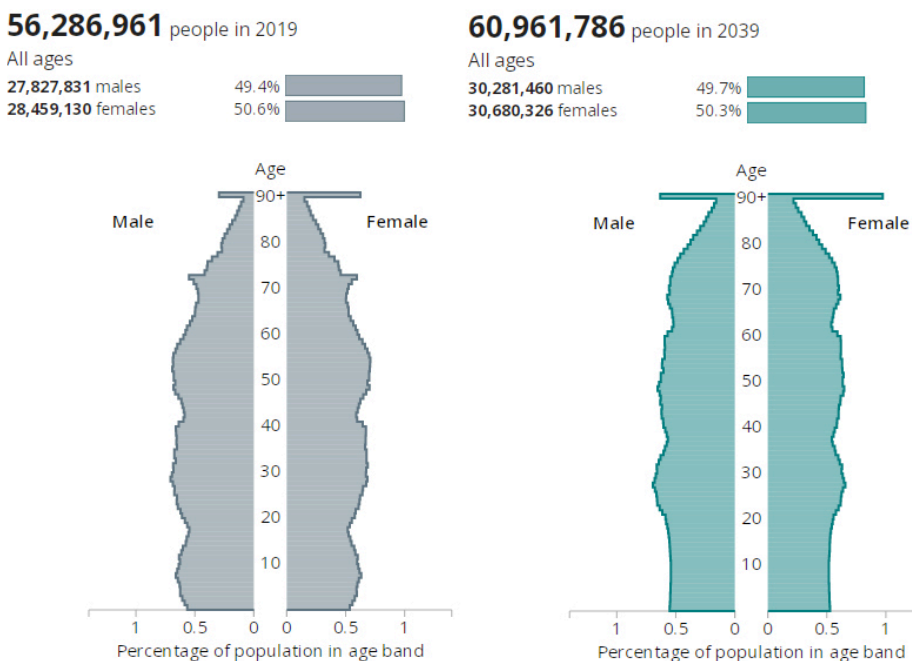


Figure 1: The age and sex structure of a population varies by local area
Population pyramids for England, by sex and single year of age, explorable by local authority and constituent country, 1999, 2009, 2019, 2029, 2039

Source: Office for National Statistics, Northern Ireland Statistics and Research Agency, National Records of Scotland and Welsh Government ([visit here](#)).

The statistics presented on population, combined with the huge drop seen in social care spending over the last decade, presents a growing problem for the future. An increasing older population suggests more people at risk of malnutrition, more people with unmet care needs and the changing requirements of the current older population continuing to be ignored.

Solutions exist which have been proven to be cost effective and in the long term could reduce the economic burden of malnutrition as well as increase support for older people. There is an economic as well as ethical argument for a change in practice,²⁴ but change is slow to happen despite the evidence of malnutrition remaining in our society.

**£4.75
million**

**Over the next 20 years
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Risk factors explained

While malnutrition is not an inevitable part of ageing, many of its common medical, physical and social risk factors do occur in later life and can affect older people cumulatively.

As the section below demonstrates, the prevalence of such risk factors is widespread and likely to increase as our population ages. As a result, unless further action is taken, the number of older people who are at risk of malnutrition or indeed malnourished in the UK is set to rise significantly.



Medical and disease-related factors

Our risk of living with one or more long-term conditions (e.g. COPD, cancer, rheumatoid arthritis, stroke, dysphagia, diabetes or dementia) increases as we age. With our population ageing, this means an increasing number of us are living into older age with long-term conditions and/or disabilities.

In many cases, long-term conditions can affect people's ability to maintain adequate nutrition levels, putting them at risk of malnutrition.

If left unsupported, people's nutritional status may deteriorate and lead to further health complications. What's more, many people living with long-term conditions often tend to have more than one comorbidity, which further increases their risk of malnutrition.²⁵

While around 65% of people aged 65 live with one or more long-term condition(s), this proportion rises to 90% among those aged 85.²⁷ This means that nine out of ten people aged 85 live with at least one long-term condition. Likewise, over a fifth of people aged 85 and over live with five or more long-term health conditions.²⁸

A consequence of increased numbers of people living with long-term conditions is that the incidence of malnutrition is likely to increase.

Disease-related malnutrition is commonly seen in clinical and hospital settings and is closely linked to ill health. However, it is not limited to clinical settings and disease-related malnutrition is increasingly being observed in the community.²⁹

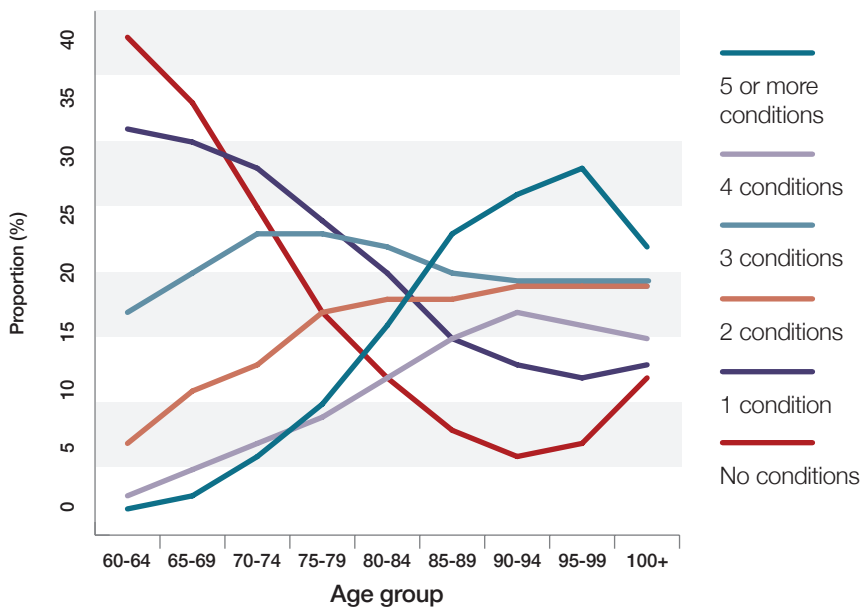


Figure 2: Number of health conditions by age group in England, 2014

Source: Age UK and University of Exeter Medical School, 2015²⁶

* Note: 2015/16 is based on population estimates and 2020/21 to 2035/36 on population projections.

Chronic obstructive pulmonary disease (COPD)

Between 700,000 and 900,000 people in the UK have been diagnosed with COPD, affecting around one in ten people over 75, and it has been estimated that a further 2 million remain undiagnosed.³⁰ The prevalence of COPD rises steadily from age 60 to 64 to the mid-80s for both men and women.³¹

Disease-related malnutrition is common among people living with COPD, due to the potential loss of appetite or breathing problems the condition brings, making it difficult for people to complete a meal. Estimates show that between 30% and 60% of inpatients and 10% and 45% of outpatients living with COPD are at risk of disease-related malnutrition.³² Similarly, people living with COPD and a lower BMI are more likely to experience health complications and die early.³³

COPD-related deaths account for approximately 30,000 deaths each year in the UK, with more than 90% of these occurring in the over

65 age group.³⁴ The rate of mortality for respiratory disease in the UK is almost double the European average. COPD is also the second highest cause of emergency admission in the UK and accounts for more than 1 million 'bed days' each year in hospitals.³⁵

Dementia

Although the prevalence of dementia increases with age, it is not an inevitable part of ageing. The prevalence of diagnosed dementia is very low (0.3%) for both men and women aged 60 to 64 and then rises slowly to four% for 75 to 79-year-olds of both sexes.³⁶ However, for women, prevalence then rises quite steeply to 29.7% of 95 to 99-year-olds. For men the rise is less steep, peaking at 20% for 95 to 99-year-olds.³⁷

Dementia or cognitive impairment can change the way someone eats. Changes may include forgetting to eat and drink, a reduced sense of satiety or finding structured meals too overwhelming.

This can be a challenge for carers in knowing how best to support their loved ones especially in the case of those who are often very active. Food preferences can change dramatically, meaning previously preferred food goes uneaten.

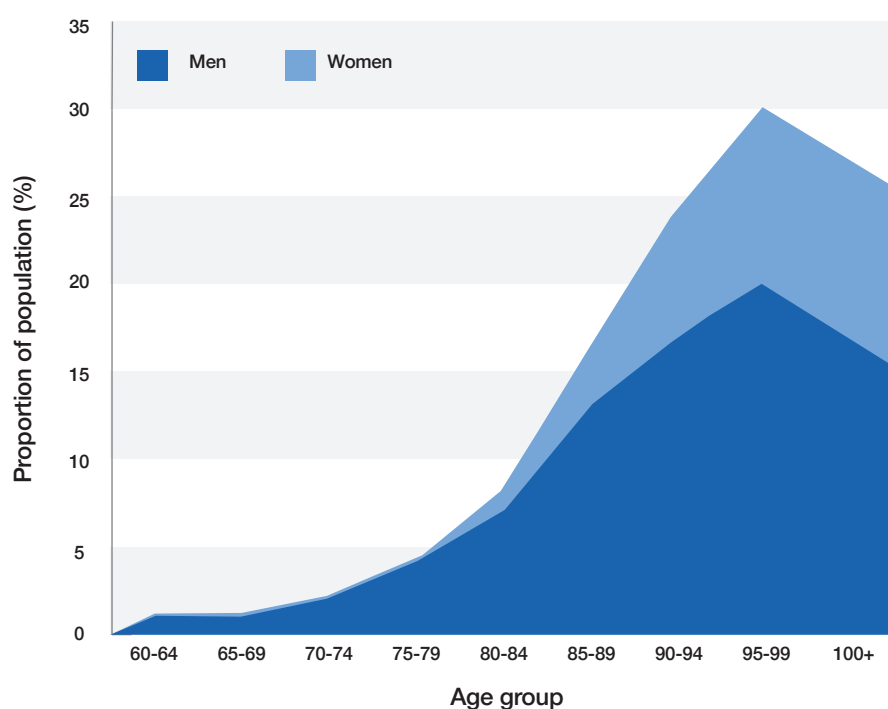
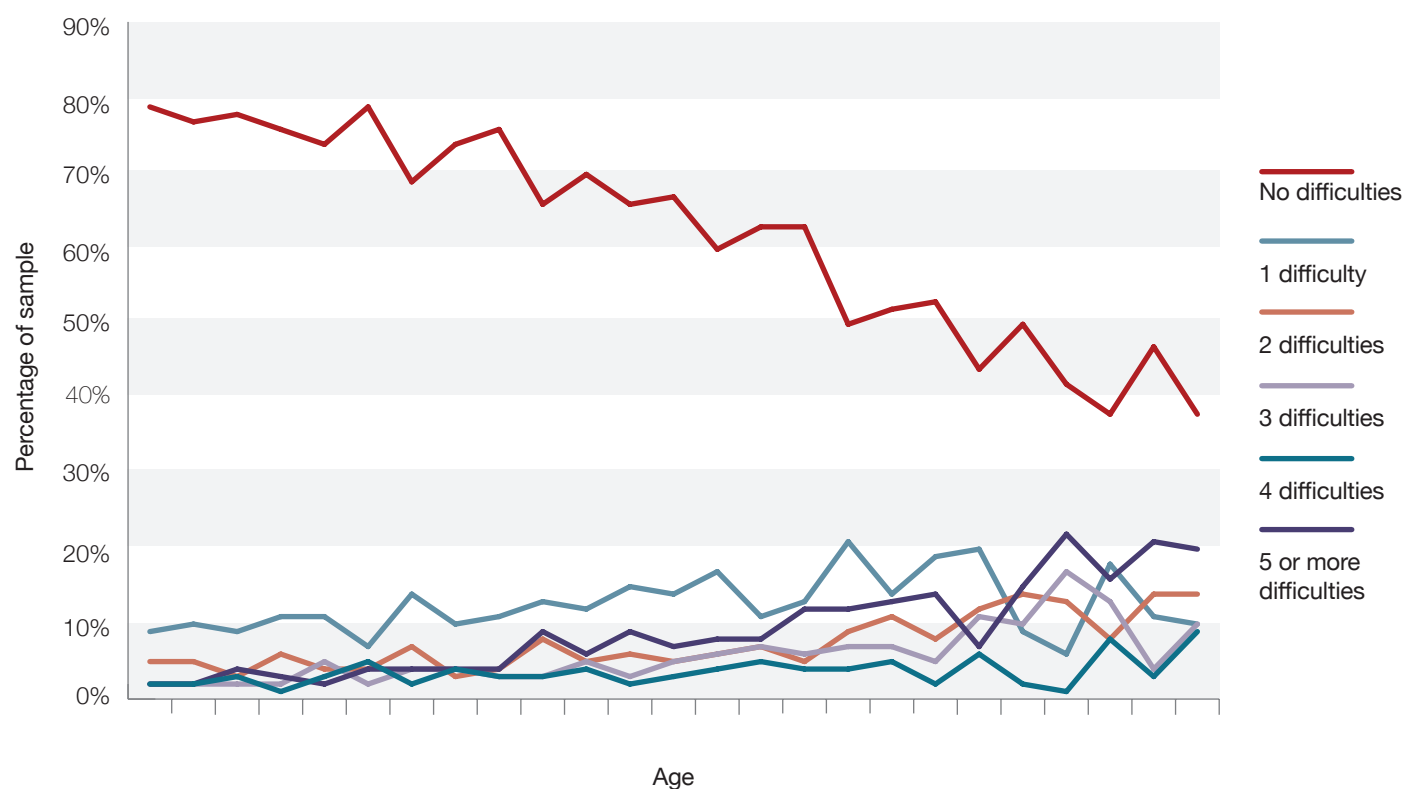


Figure 3: Proportion of population with a diagnosis of dementia by age group

Source: Age UK and University of Exeter Medical School, 2015³⁸

Figure 4: Number of difficulties with activities of daily living by age, England, 2012/13



Source: Age UK Briefing, *The Health and Care of Older People in England*, 2015³⁹

Physical and disease-related factors

Activities of daily living

As people age they may find everyday tasks more difficult. The risk of malnutrition can be influenced by changes if it means it becomes harder for someone to reach the shops, carry food or manage purchases, or cook and prepare meals.

The proportion of people who have difficulties with activities of daily living increases with age. The percentage of people with at least one difficulty increases from 21.2% at age 65 to more than half aged over 85.⁴⁰ Around one in five people in their late 80s (85+) have difficulties undertaking five or more activities of daily living, including cooking, tidying and shopping.

Mobility and accessibility

Whilst shopping services exist and are a lifeline for many, they are not universal. For those without friends or family to help, shopping can become challenging and limited to poorly stocked or expensive local shops.⁴¹ Indeed mobility problems and food access affect a large number of older people, but as a contributor to malnutrition it is largely unrecognised or ignored.

Surveys of older people found that:

- ✦ The proportion of people with multi-morbidities among those aged 65-74 is 46%. This proportion increases to 69% among those aged 85+
- ✦ 11% of those aged over 65 say they find it difficult to access a corner shop.
- ✦ 12% find it difficult to get to their local supermarket.
- ✦ 28% of rural households do not have access to a supermarket within 4km.
- ✦ 12% of people aged 65 and over in England report finding it very difficult to get to their doctor's surgery.⁴²
- ✦ The proportion of people living with frailty rises with increasing age; 6.5% in those 60-69; 65% in those 90+
- ✦ Among people living with frailty, difficulties in performing activities of daily living and IADLs were reported by 57%-64%, respectively, vs 13%-15%, respectively among non-frail individuals
- ✦ Persistent loneliness can have a significant negative impact on well-being and quality of life

Sensory loss

For those with sight, hearing or dual sensory loss, shopping and preparing food can be a huge challenge. For instance, when pouring liquids there is a risk of burns or scalds. Food safety is compromised when there are difficulties with seeing dials on cookers/microwaves and reading cooking instructions and/or sell by dates.

Almost half of older people registered as blind were first registered as partially sighted. This means that many older people have to learn and relearn how to adapt to sight loss as their sight deteriorates.⁴³

There are just over 2 million people aged 65 and over living with sight loss in the UK. It is reported that people with sight loss are much more likely to have problems with day to day living, feel their quality of life is lower, feel less satisfied by life, have lower confidence, lower levels of wellbeing, and higher levels of depression.⁴⁴

Dentition

Good dentition is a key aspect of preventing malnutrition in older people. Social participation, communication and dietary diversity have all been found to be affected by oral health.⁴⁵

In particular, pain, loose teeth and poorly fitting dentures can lead to a reduction in the variety of foods a person can eat and have a real impact on their nutritional health. Quite simply, if eating is painful or difficult, dentures move or food gets caught, it not only makes eating challenging, but puts people off eating.

Support with eating and drinking

There are several reasons why older people may need extra support with eating and drinking, such as disability due to arthritis, dysphagia and dementia. However, a survey of patients staying in hospital in 2012 found that about a quarter of all survey respondents needed support with eating during their hospital stay.⁴⁶

Of those who needed help with eating, more than one in three (38%) reported that they only sometimes received enough help with eating from staff, or did not receive enough help from staff.⁴⁷ This was estimated to be equivalent to around 1.3 million people on an annual basis, of whom about 640,000 are aged 65 or over.⁴⁸

Social Factors



There are a wide range of social factors that can contribute to malnutrition; these often overlap with health conditions and disability.

Income

Low income remains a significant contributor to poor health and wellbeing among older people. This is because it can affect access to basic necessities like heating, transport and food as well as opportunities to meet people, socialise and stay in touch with family and friends.

This can lead to loneliness, isolation and depression and an overall reduction in quality of life. Low income can clearly affect someone's ability to purchase nutritious food in adequate quantities and travel to shops to purchase food.

- 1.6 million pensioners were living in relative poverty (defined as having incomes below 60% median income after housing costs) in 2011/12.⁴⁹
- 900,000 pensioners were in severe poverty (incomes below 50% median income in 2011/12).⁵⁰
- 3 million people over the age of 60 have reported skipping meals to cut back on food costs.⁵¹
- Over one-third of people aged 60 plus are worried about the cost of living, 27% are worried about the cost of food, and 41% are worried about the cost of heating their homes in the winter.⁵²



There are just over 2 million people aged 65 and over living with sight loss in the UK. ⁴³



More than 1 million older people in the UK say they often or always feel lonely.⁵³

Loneliness

The experience of loneliness in older people is worryingly common and has been found to be frequently under recognised or diagnosed. More than 1 million older people in the UK say they often or always feel lonely.⁵³ Feeling lonely may not mean someone is isolated, it is often related to a sense of loss of a role or that there is a lack of a peer group to identify with. It should also be remembered that some people can feel lonely in a group and many others enjoy being alone.

However loneliness and a lack of sense of belonging or purpose can lead to depression, a lack of interest in food and cooking, or a belief that such activities have no value. This may increase a person's risk of malnutrition and ill health and decrease their chances of reducing their loneliness.

Isolation

Isolation is a significant risk factor for malnutrition; good appetite has been found to be linked to eating with others and poor appetite to eating alone. Isolation is defined as a lack of contact with other people and may be as a result of physical factors preventing someone from leaving their home or social factors such as moving house in later life, a lack of engagement within their community or support to do so. According to a survey in 2014, 2.9 million people aged over 65 in Britain feel they have no one to turn to for help and support.⁵⁴

Physical isolation may also mean difficulty shopping or preparing food leading to poor diet. Whilst it is important to note that a person can be socially isolated without feeling lonely, enforced isolation can lead to loneliness, depression, loss of appetite and ill health.

Transitions in later life

Transitions in later life, such as suffering from a bereavement or becoming a carer for a loved one, can also lead to loss of appetite and struggling to cook and maintain good nutrition. Yet those life changes are common among older people.

Every year, over 2.1 million adults become carers and almost as many people find that their caring responsibilities come to an end, meaning that caring will touch the lives of most of the population.⁵⁵ However, the number of carers over the age of 65 is increasing more rapidly than the general carer population. While the total number of carers has risen by 11% since 2001, the number of older carers has increased by 35%.⁵⁶ Today, almost 1.3 million people in England and Wales aged 65 or older are carers.⁵⁷

As people get older, bereavements occur more frequently and are more common. Older people commonly experience loss of a husband, wife or partner, siblings and other relatives, friends, former colleagues and associates. Loss through bereavement can be a major stress, and along with other losses experienced in later life, can reduce older people's ability to cope and be independent. In practical terms, their life may have changed dramatically. People may have less money and have to eat, sleep and live alone for the first time, or be faced with household or financial tasks that they haven't done before. They may become lonely and isolated, and lose appetite or struggle to cook for themselves.

A separate report from the Malnutrition Task Force (planned for November 2021) will go into more detail explaining how the COVID19 pandemic has affected people's health and well-being.

**1.3
million**

Today, almost 1.3 million people in England and Wales aged 65 or older are carers.

How well is malnutrition being tackled?

We know malnutrition is a significant and growing problem, but how well informed are our services and individuals to tackle it?

This section looks more closely at the evidence available and the challenges to a changing health and social care system, through workforce trends and the availability of services.

Screening, identification and treatment of malnutrition is key to ensuring that people get appropriate treatment. As stated above, we know that a large majority of malnourished people live in the community and as a result, may be hard to reach with services and treatment. Once connected with parts of the health and social care system, it is much easier to screen people and identify risk.

For many people, the GP will be the main point of contact with the health and social care system. Many local areas have a malnutrition pathway so that when someone is identified as being at risk there is a clear way for them to access support and services.

In 2015, NHS England issued their Commissioning Guidance. This was to advise local areas how they should assess their local patterns of risk and ensure adequate services are in place to meet demand.⁵⁸

This Commissioning Guidance now needs to be reviewed and updated in line with the current health and social care landscape, which is different to that of 2015-2018.

As part of the NICE Clinical Guideline 32 for Adult Nutrition Support and its' associated NICE Quality Standard 24 where the recommendations included nutrition screening for malnutrition risk in all care settings, most hospitals and care settings are now routinely checking whether someone is malnourished or at risk of malnourishment.

This is especially the case when people are admitted into a setting. This is of course very welcome

progress and helps us understand the prevalence of malnutrition.

The Care Quality Commission (CQC) has incorporated screening for malnutrition risk into its' hospital and care home inspections.

However, there is further opportunity for screening to be incorporated into all CQC inspections in all care settings and to have additional questions which enables CQC inspections to uncover what happens if/when someone is screened and found to be at risk.

However, we know there is still progress to be made to ensure that these screenings are reliable and effective. For example, work by BAPEN in care homes identified that whilst in 90% of care homes nutrition screening was standard, there were inconsistencies in using and calibrating the equipment as well as translating the findings into the care plans in place for individuals.^{13, 14}

We also know that health and care professionals are operating in an environment which is under extreme pressure from increased and increasing demand as well as cuts to funding, difficulty in filling vacancies, high staff turnover and management and policy reorganisation which may be a distraction from the day-to-day care provision.



As part of the NICE guidelines for nutrition screening, hospitals and care settings are now routinely checking whether someone is malnourished or at risk of malnourishment.



Workforce trends

Current trends in funding and service provision for care provide a worrying picture of the impact of changes to budgets and workforce. However, there is very little data on how workforce trends are changing with regard to older people's care.

Whether the decrease in community support has led to the need for acute services to rise is unclear, but the picture suggests that less support through NHS staff is available for prevention and follow up or discharge care. This may be simply a change in

the way funding is allocated. Increasingly, services have been taken out of the community and into GP surgeries. Surgeries now offer a wide range of services including specialist clinics, minor surgery and routine treatments.

The presence of tools such as the Patients Association Nutrition Checklist which is a simple tool to help people to have a conversation about eating and drinking, plus BAPEN's Self-Screening tool for patients and carers to help identify risk; then for professionals there is the Malnutrition Universal Screening Tool, the Managing Adult Malnutrition in the Community Pathway which means that there is no excuse for not recognising and managing malnutrition in an appropriate person centred way.

However, the health and social care landscape in England is changing and the service provision to meet the needs of the local population is coming into practice. Therefore, now is a great opportunity to incorporate the prevention and management of malnutrition into the foundations of the local health and social care infrastructure and the associated appropriate support services and pathways.

- ❖ Numbers of NHS staff across all settings and disciplines has increased in recent years. The number of doctors has increased by nearly 11% in the years between December 2009 and December 2016. However, the number of nurses and health visitors increased by just under 2% in the same time period.⁵⁹
- ❖ There are only 9,738 dietitians in the UK working across a range of specialist areas not just with older people or in the community.⁶⁰
- ❖ Support for malnourished older people appears limited unless directly referred through hospital or GP.

Health care and the NHS

Awareness among health professionals

A survey by Dods for the Malnutrition Task Force interviewed health care professionals on patient experiences of malnutrition.⁶¹

It found that:

- ❖ Professionals whose role involves frontline care were significantly more likely to identify preventing and treating malnutrition as a high priority than those whose role does not involve frontline care (33% and 20% respectively).
- ❖ Senior staff and those with financial responsibility were more likely to consider this issue a low priority.
- ❖ Overall, 47% of health and care professionals felt confident in their knowledge and skills to identify and treat older people at risk of malnutrition, increasing to 60% for those respondents whose role involves front line care.
- ❖ 51% of health & social care professionals stated that tackling malnutrition was a high or medium priority.
- ❖ Unfortunately, 54% didn't know if services were in place to tackle malnutrition, 55% didn't know about support services and 61% were unaware of a pathway to tackle malnutrition.

The level of awareness suggested by the Dods survey is encouraging and there appears to be a clear desire to tackle the issue.

However, the data also suggests that the main drivers for this are those individuals working directly with older people and that more senior staff do not see malnutrition as a priority. The lack of awareness of services, support or pathways means that there is still much work to be done.



There is guidance, and there are various tools and resources, in abundance and it is now the time for action.⁶² In 2018 the Patients Association launched a simple Nutrition Checklist which helps to encourage a conversation about eating and drinking, and signpost people.

In 2015, BAPEN launched the first Malnutrition Self-Screening Tool for use by individuals and/or their carers who are concerned about malnutrition.⁶³

There are also tools and resources developed by the Malnutrition Task Force and its' pilot sites that can be found on the Malnutrition task Force website.

For professionals, the Managing Adult Malnutrition in the Community Pathway is available, a practical guide and pathway to assist community healthcare professionals in identifying and managing malnutrition, and local areas have developed their own pathways tailored to their local population.⁶⁴




The health care system needs to shift away from the view that malnutrition is a target for cost cutting and instead nutrition should be incorporated into all care pathways forming an integral part of care for all people.



There are only 9,738 dietitians in the UK working across a range of specialist areas.

Nutrition in hospitals

A recent survey in hospitals has found widespread inconsistencies in standards of care with regard to dignity and nutrition.⁶⁵

-  **Poor or inconsistent standards of help with eating affected 1.3 million inpatients (38% of total inpatients), 640,000 of whom were over 65.**
-  **Of those who needed help, one in three reported that they only sometimes received help or did not receive enough help.**
-  **Between 2005 and 2012 there has been little change in the percentage of people affected by poor standards of help with eating. Analysis by the Care Quality Commission suggests this has not changed between 2012 and 2014.**

Whilst there is much good work going on to improve nutrition in hospitals and the nutritional status of patients, it appears patient experience has changed little and the lack of standards of nutrition and nutritional care in hospitals is contributing to patients' risk of malnutrition.

Although screening on admission to hospitals is recommended⁶⁶ and quality standards exist to support the implementation of effective screening and assessment, at present it is not a mandatory requirement to assess a person's nutritional status as they are admitted to either a hospital or care home. Similarly, screening is recommended on registration at GP surgeries and through initial use of domiciliary care and local authority day care services, but there is no data collected on the extent to which this takes place.

If services are inadequately co-ordinated or there is a breakdown in the continuity of care then people become more vulnerable to the risks of malnutrition. This is especially the case when people are

discharged from hospital to their home and the care needed shifts from health to social support.⁶⁷

While patients can 'fall through the gaps' in services, the changes in the way these services are funded and allocated has created ever widening spaces between the needs of the individual and the support available in their circumstance.

This is also the case with medical conditions which we know might lead to malnutrition, in these cases the malnutrition pathway could be incorporated or work alongside a treatment plan.⁶⁸ For example, in the case of depression, a report by the Royal College of Psychiatrists found that 85% of older people with depression receive no help at all from the NHS.⁶⁹

We know that appropriate diagnosis and timely treatment of malnutrition can reduce costs and pressure to the health care system by ensuring malnutrition is resolved in clinical settings,⁷⁰ but there are many options to help the person, not just treat the condition.

The current system does not appear to have the support systems in place to ensure that older people are appropriately assessed for risk and regularly screened for malnutrition.

Whilst there appears to be more awareness of the issue generally in health care, survey data suggests there is much more to be done.⁷¹

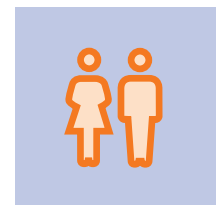
Discharge and recovery is an important transition for older people suffering or at risk of malnutrition. Good and clear communication with older people directing them to next steps and signposting to further support and services would reduce the readmissions. In a survey, most patients (80%) say they are not followed up at all by their GP or anyone else about their nutritional needs.⁷²

Social care

It is thought that the high percentage of people who are malnourished and living in the community (93%) may result from having inadequate access to services, being housebound or having limited mobility.⁷³

Long-term conditions or more than one condition can contribute to an increased risk of malnutrition, but also to care needs. Often this situation is made more difficult for the person by the lack of a support network to assist with day to day tasks such as shopping, cooking or help at mealtimes.

In terms of social care support, there has been a significant decline in social care budgets and spending. There has now been a £160 million cut in total spending in real terms on older people's social care in the five years to 2015/16.⁷⁴



Of those who reported that their main care came from an informal source, 56% said this was from a husband or wife.



Care needs

Analysis by Age UK⁷⁵ demonstrates the growing disparity between care needed and care provided to older people, particularly in England.

- ❖ The level of unmet need continues to grow and it is now estimated that nearly 1.2 million people over 65 don't get the help they need with essential daily activities of living.
- ❖ This reflects the overall decline in spending by Local Authorities as a result of central Government funding cuts – the National Audit Office estimates that Local Authority funding reduced by 25% in real terms between 2010/11 and 2015/16.⁷⁶

A decrease in budget for social care for older people has had a negative impact on providers' ability to support older people at risk and prevent the older person from becoming malnourished. Instead, it has forced the focus of care on those already in crisis, whilst those at risk may be one step away from crisis themselves.

BAPEN has undertaken snapshot surveys in care homes and these show that around 90% of homes screened were using a screening tool to determine the status of their residents. However, it is unclear whether the information obtained in the screen affects care provision and how often the person is re-screened to check whether interventions are successful.

Help and support at home

Age UK's analysis of the English Longitudinal Study on Ageing⁷⁷ found that

- ❖ It is thought that more than half of those living with one difficulty do not have their needs met.
- ❖ 37.8% of those who reported a difficulty received no support.
- ❖ Worryingly, those with five or more difficulties (42,000) also get no help.

A 'difficulty' can be defined as a daily activity (getting dressed, washing, eating) and instrumental activities (taking medication, cooking, shopping) which allow people to live independently.⁷⁸

Of those who reported that their main care came from an informal source, 56% said this was from a husband or wife, but support also came from children, grandchildren, neighbours and friends.⁷⁹ Indeed, there has been an increase in the number of unpaid carers of all ages over recent years, with the numbers of people providing care rising from 16.6% of the population in 2011 to 17.6% by 2014.⁸⁰

Overall there were 206,000 reports of help given by informal carers.⁸¹ Meanwhile, data from the Health and Social Care Information Centre in 2014⁸² shows only 38,000 care assistants reported that they supported someone with eating. Even allowing for some individuals reporting informal care from more than one person, this discrepancy in the figures suggests that without informal care people would be getting little or no support to eat. This figure, plus the huge number of people getting no support at all suggests a significant risk of malnutrition for the older people involved.

Research by Carers UK shows that not only are older people at risk, but often their carer as well. The stress of caring for a loved one can lead to the carer becoming malnourished and increasing their risk of ill health.⁸³

The research found that:

- ❖ 60% of carers worry about the nutrition of the person they care for and one in six carers is looking after someone at real risk of malnutrition, but do not have nutritional support of any kind.
- ❖ The number of carers over the age of 65 is increasing more rapidly than the general carer population.

The consequences of malnutrition therefore increase the level of dependency someone has on their family or support services as well as the worry and anxiety a carer feels when their loved one is not eating well. This in turn can have a negative impact on carers leading to a loss of other social relationships, depression and the increasing sense of helplessness which can be associated with caring for someone you love and coping with the changes this brings.⁸⁴

Part of addressing malnutrition is acknowledging the vital role that carers play and supporting them to feel able to help tackle malnutrition in both the person they care for and for themselves. Information must be freely and easily available to empower carers.

This is part of ensuring that malnutrition is addressed holistically, taking the whole person into account and looking at various methods to support them nutritionally.

Local support

Community projects including day centres, lunch clubs, shopping support services, befriending services and community meals have been found not only to be cost effective, but to successfully address many of the causes of malnutrition.⁸⁵

For many people, a combination of support services can provide a way for them to remain independent and healthy. In recent years, budgetary restrictions have led to changes in the way care is provided meaning community support services provided by Local Authorities have also tightened eligibility or reduced services.

Community meals provide an important resource for people who are unable to shop for food or prepare their own meals. Research by the Association for Public Service Excellence has shown that just under half (48%) of Local Authorities provide meals, compared to 66% only two years ago.⁸⁶

The change in costs at a Local Authority level can mean older people can no longer access services previously available to them. Between 2005/6 and 2012/13, the number of older people using day care centres fell by 49%, from 136,000 to 69,100.⁸⁷

This may be as a result of a lack of referrals, changes in eligibility criteria or due to a lack of community or local authority transport available to get people out of the house and to the centres.

However, this cost saving could in turn be leading to greater problems and more malnutrition in the future. A lack of investment in preventative services means those with moderate needs may find their needs increasing and without adequate support they are exposed to a greater risk of malnutrition and poor health.

People slip through the gaps in a way that could be prevented if their potential to become vulnerable was addressed.

The number of carers over the age of 65 is increasing more rapidly than the general carer population.



Getting it right: building on good practice and existing guidelines

There is much that is heartening about the efforts to tackle malnutrition across all care settings and among health and social care professionals. So, what are we getting right?

- ✿ There is good practice on tackling malnutrition in the community, tackling malnutrition in those with dementia and supporting older people with their nutritional and hydration needs.^{88, 89}
- ✿ There are simple tools that can be used by people as first line to help encourage a conversation about eating and drinking such as the Patients Association Nutrition Checklist. This is to help start a conversation and help sign-post people.
- ✿ Validated tools exist and are endorsed by a wide range of organisations. The 'Malnutrition Universal Screening Tool' ('MUST') is a clinical tool used to screen for malnutrition. Elsewhere, BAPEN have developed an online self-screening tool so people can check if they or someone they know are at risk.⁹⁰
- ✿ There is good Guidance available on adult malnutrition and nutrition support, commissioning services and using nutritional supplements.^{91, 92, 93}
- ✿ A multi-professional endorsed evidence based pathway is available for GPs to use, Managing Adult Malnutrition in the Community,⁹⁴ which clearly outlines how to recognise through to how to manage malnutrition.

So, for older people and the services that support them, it means that the information, guidance and support are in place, so there is no excuse for not acting.

We all have a responsibility and can help, from just simply having a conversation through to screening for malnutrition risk and understanding what to do depending on the situation

Training of all health and social care staff, particularly those who act as gate keepers such as GPs, is critical in developing measures to effectively tackle

malnutrition in the community. However, it is also important that everyone is aware of what they can do if they think someone is not eating so well.

There are currently e-learning modules in place through different routes meeting the needs of different people such as the e-learning for GPs through the Royal College of GPs, community pharmacist e-learning, carers e-learning available through the Carers UK website on eating well; there is also e-learning focused specifically on frailty such as that available through the Wessex AHSN; information local to the Malnutrition Task Force Pilot sites.

There are still gaps, mainly in public awareness and professional training, but the building blocks are there to create better nutrition for all older people and to make the standards and availability of care universal.

Work has already started to address the hidden problem of dehydration among older people, to increase awareness and improve hydration as a fundamental part of good nutrition. The National Hydration Network has made some great progress and continues to drive positive change in this area.

The Malnutrition Task Force continues to work with others, some examples include those originally involved in the Malnutrition Task Force pilot sites such as Manchester, Dorset, Lambeth & Southwark, Gateshead who have developed their own tools and continue to champion the prevention, better (and earlier) identification of malnutrition and earlier management of malnutrition.

If the way in which we address malnutrition does not change, we can only expect the situation to worsen for the older people at risk of malnutrition and those of us who care for them.

Preventing and treating malnutrition relies on increasing public awareness and professional training, alongside an integrated system of health and social care and with support for older people, their carers and families.

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Established in 2012, the Malnutrition Task Force raises awareness and provides information and practical guidance for everyone to help combat preventable undernutrition and dehydration in later life.

Our aim is to share our expertise and work with our partners in hospitals, care homes, local authorities and private and voluntary organisations.

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