



# Hidden hunger and malnutrition in the elderly

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## Summary

### The extent of malnutrition amongst older people

Malnutrition arises when a person's body does not gain the nutrients it needs to function properly. Older people are particularly at risk of becoming malnourished, due to a range of unique medical, physical, and social reasons.

The availability of data on the numbers of older people in this country who are hungry or malnourished is limited, to put it mildly.

The most robust estimate presented to us suggests that in 2011, 1.3 million older people were malnourished or at risk of malnutrition. We have not been able to find an updated figure.

We recommend that Public Health England and its equivalent bodies in Wales, Scotland, and Northern Ireland, should regularly record and publish up-to-date data on the extent of malnutrition amongst older people.

Some malnutrition amongst older people may be caused by poverty. Another, and perhaps main cause, is social isolation brought about by the loss of one's partner or an unwillingness to draw attention to one's suffering, for example.

Compared with 2011, there are now 100,000 fewer pensioners living in absolute poverty. Nonetheless, we estimate that there are at least as many older people who are malnourished or at risk of malnutrition today, as there were seven years ago.

Hospitals rarely record malnutrition as a primary reason for admission, with primary causes such as disease, illness, injury, or infection often being diagnosed. Even so, figures from the House of Commons Library show that the number of people aged 60 and

over whose primary diagnosis was malnutrition, more than trebled in the decade between 2005-06 and 2015-16; from 283, to 921.

However, the evidence we have received suggests that even these data do not in any way adequately capture the full extent of the problem. Older people are classified upon entering hospital by the immediate cause of their injury or ill health, such as a fall or another accident, but the data do not tell us how influential malnutrition may have been, in weakening their body and mind, as a factor which led to that fall or accident.

We believe that in an attempt to limit the risk of injury or ill health associated with malnutrition, robust and reliable screening tools must be scaled up across the country so that malnutrition can be identified, diagnosed, and treated much more quickly and effectively in the community.

We call on the Secretary of State for Health and Social Care to ensure that at all levels of care, staff are trained to use the Malnutrition Universal Screening Tool, or an equivalent mechanism, to identify older people who are at risk of malnutrition and ensure they receive appropriate food and support to improve their condition.

### The underlying causes of malnutrition amongst older people

The evidence we have received suggests that malnutrition is most likely to arise amongst older people following an accumulation of setbacks – bereavement, illness, a loss of community transport services, and a nearby shop closing, for example – which leave them unable easily to access food.

Over and above these cumulative setbacks, the evidence we received crystallised around three underlying causes of malnutrition:

loneliness and social isolation, the diminished availability of Meals on Wheels, and inadequate social care packages.

### The cost to the NHS and social care services of malnutrition amongst older people

Malnutrition amongst older people delivers not only human misery, but also a large and growing bill to the NHS and social care services.

Based on a House of Commons Library analysis of BAPEN figures from 2011, we estimate the total annual cost to our country's health and social care services of malnutrition amongst older people to be £11.9 billion. We estimate also that this sum will increase to £13 billion in 2020, and again to £15.7 billion by 2030.

The evidence presented to us suggests that the increased direct and indirect costs associated with malnutrition arise from more frequent admissions to hospital, longer stays in hospital, and a greater occurrence of ill health which necessitates visits to GP surgeries. Malnutrition has a severe impact not only on older people's general health, but also on their ability to recover from injury or ill health – bones and muscles in malnourished bodies are more easily damaged and take longer to heal.

We believe that targeted investment in services which protect older people from malnutrition would deliver significant annual savings to the NHS, not least by reducing the number of hospital admissions and limiting the number of days older people spend in hospital.

### The range of schemes that exist to counter malnutrition amongst older people

There are some hugely innovative examples of community organisations protecting older

people from malnutrition, through either home visiting services or the provision of communal meals. With the right levels of support, those organisations could be scaled up across the country to ensure growing numbers of older people receive the food and support they need, through small acts of kindness, to remain relatively healthy and independent.

We are reluctant to call upon the Government, or local authorities, to dig even deeper into their scarce resources to fund new initiatives – as hugely effective as those initiatives may be in countering malnutrition amongst older people. However, we believe that the Government should look carefully at how existing budgets could be reallocated among the pensioner population to help safeguard older people from malnutrition.

We recommend that the Government should consider withdrawing the Winter Fuel Payment from the very richest pensioners in this country and diverting that money to innovative community organisations that seek to protect older people from malnutrition.

As an illustrative guide, according to the House of Commons Library:

- An additional £5 million a year could be made available for the protection of older people from malnutrition, if the Winter Fuel Payment was no longer paid to pensioners with annual incomes which fall within the additional rate of tax
- Alternatively, an additional £100 million a year could be made available, if the Winter Fuel Payment was no longer paid to those with annual incomes which fall within the higher rate of tax

### New approaches to protecting older people from malnutrition

It became clear in the evidence presented to us that malnutrition amongst older people is often intertwined with loneliness and social isolation. It is not surprising, therefore, that suggestions around which new approaches are required to protect older people from malnutrition also advocated the provision of meals as a means of interacting and socialising with other people.

Two new approaches received particular attention in the evidence that was submitted to us: an enhanced home-visiting service through which adequate meals and support are delivered by community projects to those older people who might struggle to leave their own home; and a new role for supermarkets in both maintaining older people's independent shopping habits and providing weekly lunch clubs.

We recommend that social care providers, including third sector organisations, should be given a duty, and the appropriate funding to carry out this duty, of ensuring all older people at risk of malnutrition, and particularly those in receipt of formal social care, receive at least one hot meal every day with nutritional supplements provided if necessary.

We recommend also that through either a more flexible social care package, or the provision of additional support from third sector organisations, this duty should extend to ensuring older people receive the necessary help to prepare that meal and undertake any other brief activities that could, in the longer run, keep malnutrition at bay.

We also call on Britain's biggest supermarkets to open up a new front in the battle against malnutrition amongst older people. Three reforms, in particular, would move us onto the front foot in this battle:

- The provision during set times of the week of assisted shopping, including 'slow' or 'relaxed' checkout lanes, so that older people can continue to shop independently for the food they wish to eat
- Accompanying those shopping sessions with a lunch club in the in-store café area
- Subsidising the community travel that older people will require to get to the supermarket, both to buy their shopping and to attend the lunch club

There is, of course, a hugely important role for each of us as fellow citizens in looking out for our older neighbours. While this does not replace structured support delivered by social care providers, we should all nonetheless recognise our responsibilities to one another.

## Introduction

The All-Party Parliamentary Group on Hunger has been in existence for four years. Many hundreds of submissions, around the extent and causes of hunger in this country, have been presented to us in that time. Almost all of them have centred upon the poverty which exposes a proportion of families and individuals below the state pension age to hunger. Barely a handful of submissions, though, have raised the vulnerability to hunger that exists among pensioners.

The reasons for this have become fairly clear. The rapid increase in the numbers of people seeking help from food banks over the past decade – a most visible symptom of hunger in our country – has occurred almost exclusively amongst families and individuals below the state pension age. Less than one per cent of pensioners use food banks.

Another reason is that the face of poverty in this country is changing – it has become much younger over the past generation, thanks in no small part to the all-out assault on pensioner poverty that has been mounted by successive governments. There is, of course, a sizeable number of pensioners who are reliant on Pension Credit to guarantee an adequate minimum income. But the risk of poverty is now much greater among children, for example, than pensioners.

It was Feeding Britain, the organisation we established two years ago to lead the fightback against hunger and destitution in this country, which first conveyed to us concerns from volunteers on the frontline around a phenomenon that, in recent years, has largely remained under the radar: the exposure of pensioners to malnutrition or, as it was put to us in oral evidence, older people ‘starving in their homes’. Hence our desire, in establishing a short inquiry, to gain a deeper

understanding of the phenomenon and what new approaches are required to counter it.

Now, at the conclusion of that inquiry, we cannot help but ask ourselves why this social evil has been allowed to remain under the radar for so long.

We were told in oral evidence of older people spending two or three months withering away, starving, before entering hospital weighing five and a half stone with a urine infection or pneumonia which keeps them there for several tortuous days, if not weeks.

We were told also of older people living alone in high-rise flats they are no longer able to leave, ‘having services pulled from under their feet’, feeling angry, hungry, and let down.

Six pieces of evidence, in particular, illustrated the severity of the phenomenon with which we are now confronted:

- One woman in her eighties with dreadful rheumatoid arthritis, had been caring for her husband with dementia and leg ulcers. The district nurses came in every two or three days to dress his leg, administer his medication, and provide all the support he needed. But the care going to him helped his wife as well. He eventually went into a care home, but nobody thought about how his wife was coping with her rheumatoid arthritis in her eighties. It was nine weeks later when her neighbour, who had grown concerned over her wellbeing, took in some milk and found she had not eaten a meal for nine weeks.
- One woman weighed six stone and ‘probably wasn’t long for this earth’ when she was referred to the

Hertfordshire Independent Living Service. The Service told us in oral evidence that it has encountered older people, ‘literally fading away in their own homes’.

- Some older people being helped by FoodCycle are eating multiple portions of food after they arrive at the organisation’s communal meal clubs. They are ‘thin and look malnourished – and it is obvious from the speed at which they eat the food they are very hungry’.
- Up to half the older people living alone who receive meals from the Hertfordshire Independent Living Service, needed to rely upon the Service for a meal on Christmas Day because they would not receive a visit from anybody else.
- Pensioners who would normally keep the heating or lights off to save money, are turning them on only when they know that people are due to visit the house. One Meals on Wheels volunteer shared the example of an older man who would switch off the lights on his Christmas tree as soon as the team left the house, to save on electricity.
- One man in his nineties, now receiving help from The Food Train, had not been able to buy food as his local supermarket banned him. He had had two falls and they said he was too much of a threat to their liability insurance.

We look in Chapter 1 of this report at how widespread malnutrition amongst older people has, and is likely to become in the years ahead. Chapter 2 then explores the circumstances behind this phenomenon, as

well as those particular factors which result in certain groups of older people becoming more vulnerable than others. What follows in Chapter 3 is an estimate of the impact of this phenomenon on the National Health Service (NHS) and social care services, before we turn in Chapter 4 to those stunning examples of communities pulling together to improve nutrition levels among older people. We then consider in Chapter 5 a set of proposals for the beginnings of a reform programme to help counter malnutrition amongst older people for good.

Having only been able to draw upon a limited sample of evidence, our main purpose in publishing this report is to issue a rallying call for supermarkets, social care providers, third sector organisations, and the Government, to look more closely at this issue.

One of the main messages we hope the public will draw from this report is that through small acts of kindness, we can make huge strides towards eliminating malnutrition amongst older people in this country, and in so doing confront the challenge raised in evidence from the Caia Park Partnership: ‘people they say are living longer, but what quality of life do the older generation have generally to look forward to?’

The elimination of malnutrition amongst older people is urgently required for the sake of the NHS, and social care services, but above all for purposes of humaneness. Hence our central recommendation in this report, for a series of innovative pilot schemes that feed and care for older people.

## **Chapter 1 – How many older people are hungry or malnourished?**

### **A national estimate**

Malnutrition arises when a person's body does not gain the nutrients it needs to function properly. People who are malnourished, due to a poor diet, are likely to have low levels of energy and weaker muscles. They are likely also to have a weaker immune system which puts them at greater risk of picking up an infection. If they do become ill, or suffer a fall and fracture a bone, people who are malnourished are more likely to take longer to heal.

The World Health Organisation defines malnutrition as:

'deficiencies, excesses or imbalances in a person's intake of energy and/or nutrients. The term malnutrition covers two broad groups of conditions. One is 'undernutrition'—which includes stunting (low height for age), wasting (low weight for height), underweight (low weight for age) and micronutrient deficiencies or insufficiencies (a lack of important vitamins and minerals). The other is overweight, obesity and diet-related non-communicable diseases (such as heart disease, stroke, diabetes and cancer).'<sup>1</sup>

Older people are particularly at risk of becoming malnourished, due to a range of unique medical, physical, and social reasons which we outline in Chapter 2. However, the availability of data on the numbers of older people who are hungry or malnourished is limited, to put it mildly.

The most robust estimate presented to us suggests that in 2011, 1.3 million older people were malnourished or at risk of malnutrition.

This estimate is based upon survey work completed between 2007 and 2011, by the British Association of Parenteral and Enteral Nutrition (BAPEN). We have not been able to find an updated figure, and no equivalent estimates exist in respect of hunger.

**We recommend that Public Health England and its equivalent bodies in Wales, Scotland, and Northern Ireland, should record and publish data on the extent of malnutrition amongst older people.**

Some malnutrition amongst older people may be caused by poverty. Another, and perhaps main cause, is social isolation brought about by the loss of one's partner or an unwillingness to draw attention to one's suffering, for example.

Compared with 2011, there are now 100,000 fewer pensioners living in absolute poverty.<sup>2</sup> Nonetheless, we estimate that there are at least as many older people who are malnourished or at risk of malnutrition today, as there were seven years ago.

Age UK suggested in written evidence that, 'the numbers could be higher', as 'most older people become malnourished in their own homes and, in many cases, the problem is never acknowledged or addressed [...] particularly among housebound older people including those who are hard-to-reach or more isolated'.

<sup>1</sup>

<http://www.who.int/features/qa/malnutrition/en/>  
<sup>2</sup> Table 6a of the Households Below Average Income, 1994/95 to 2015/16, series published by the Department for Work and Pensions shows that

in 2011/12 the number of pensioners living in absolute poverty, after housing costs, stood at 1.7 million. By 2015/16, this number had fallen to 1.6 million.



Likewise, Church Urban Fund reported to us that, ‘there may [...] be underreporting of food insecurity amongst older people, for example, due to generational tendencies to “make do” or “not make a fuss” about difficulties, or the desire to maintain pride or dignity and the impression that one is coping’.

The Caia Park Partnership Older People’s Day Centre, in a submission presented to us by Ian Lucas MP, also commented on how, ‘the older they are the more difficult it is to get [people] to admit they are short of food or even going hungry at all. It’s probably a generational trait as they feel they shouldn’t complain and just go without instead’.

This pattern of behaviour was captured in oral evidence, too, by Wendy Wills, Director at the Centre for Research in Primary and Community Care: ‘Older people tend to wait longer before they ask for help, or someone else realises that they need help. So they hang on for longer’.

### Who is particularly vulnerable to malnutrition?

Managing Adult Malnutrition in the Community sought in its submission to identify particular groups of older people who are at risk of malnutrition, in particular people with:

- A chronic disease (e.g. chronic obstructive pulmonary disease (COPD), cancer, gastrointestinal disease, renal or liver disease and inflammatory conditions such as rheumatoid arthritis, or inflammatory bowel disease)
- A progressive neurological disease (e.g. dementia, Parkinson’s disease, or motor neurone disease (MND))

- An acute illness which leaves them unable to eat for consecutive days
- Mobility issues (e.g. the frail, elderly, and depressed, or those recently discharged from hospital)
- Social difficulties (e.g. poor support, housebound, unable to cook and shop, or are living in poverty)

In addition, Managing Adult Malnutrition in the Community shared with us an estimate that 35% of people recently admitted to care homes are malnourished. This chimed with the oral evidence given to us by the Hertfordshire Independent Living Service, which found that approximately 40% of people referred on to its books are malnourished.

While many of the people who fall within this category are likely to be very old and frail, Feeding Britain drew to our attention another group of older people who are vulnerable to malnutrition: those aged between 55 and 70 with particularly heavy caring responsibilities. Feeding Britain explained in its submission that, ‘while their relative youth does not immediately flag them as vulnerable, they are more likely to be taking on double caring responsibilities for children [or] grandchildren as well as elderly parents. The costs of doing so, and the reduced capacity for income if people are still working, places this group at particular risk’.

Similarly, with reference to older carers who look after disabled children, Family Fund noted how, ‘it is unsurprising that we found that over half of those surveyed had found it difficult on at least one occasion over the past 12 months to afford healthy food for themselves and their family. As well as this, some respondents were getting into debt in order to buy healthy food, with over a third of respondents saying they had used credit

cards and over 20% saying they had not paid a bill’.

A third group of older people uniquely exposed to malnutrition is those who have recently lost their partner to bereavement. As explained by the Brighton and Hove Food Partnership, ‘bereavement can be an issue, when one partner holds the cooking skills. We heard from a sheltered housing worker who noticed that an elderly man in their accommodation seemed unwell after the death of his wife. She visited him in his flat and found the fridge just had chocolate in it. It turned out he didn’t know where to start with cooking for himself and they were then able arrange for him to get some support around learning to cook’.

The unique exposure of this group, according to Tim Ansell of Whitefriars Housing in Coventry, needs to be considered against the backdrop of, ‘not everyone knows how to cook [.] There does seem to be a common misconception that all older persons can cook whereas in fact a large number have limited skills and knowledge and also as they age it does become more of a challenge and chore. Motivation to cook for one is not something that everyone possesses’.

### ‘Invisible in the community’

The evidence we have looked at so far gives us a rough idea as to how many, and which groups of older people are likely to be malnourished. However, a detailed national measurement remains lacking. Clearly, if we are to ensure every older person at risk of malnutrition can receive the help they need to stay well-nourished, we must first get better at identifying the problem. Michelle Carruthers of The Food Train noted in oral evidence that, ‘so many frail older people are now invisible in the community, so we’re not fully aware [of the extent of malnutrition]’.

There is already in existence a nationally validated screening tool, developed by BAPEN, known as the Malnutrition Universal Screening Tool (MUST). However, it is not used routinely to collect national data. The Brighton and Hove Food Partnership explained in written evidence how, ‘MUST screening should pick up malnutrition, but although well used in hospitals, [it] isn’t adequately rolled out in community settings which is the most important time to pick up malnutrition’.

Sarah Wren of the Hertfordshire Independent Living Service expanded upon this point in oral evidence:

‘[Identification] could become far more part of people’s daily routine, to actually find out if people are malnourished. In theory it’s done in hospitals, but that information is not always communicated when people go back out into the community. The NHS can then be selective about who that information is given to, so to another clinician, even though that information is vital for all sorts of people and services like ours. Care homes are improving in the use of MUST, although I’ve heard it’s not always undertaken with the rigour it should be. Domiciliary care really should be using it. That’s where it needs to sit, out in the community. It needs to become business as usual for many more agencies’.

In a paper written by Caren Watson, submitted to us by Lucy Antal of Liverpool Food People, it was suggested that, ‘malnutrition within the elderly population is not always recognised, due to factors such as the training of health care professionals’. This led Wendy Wills, Director of the Centre for Research in Primary and Community Care, to recommend to us in oral evidence that, ‘for anybody coming into contact with anyone aged over 70, this should become a routine part of that contact’.

Age UK Brighton and Hove, in a submission presented to us by Caroline Lucas MP, agreed that an ‘every contact counts’ approach should be adopted, ‘so that all those who come into contact with older people are able to spot the signs of malnutrition and ensure support is in place. This would include medical professionals, care agencies, pharmacists, befrienders, providers of services for older people, Care Coaches, podiatrists, [and] library home visit volunteers’.

Likewise, the British Dietetic Association informed us that, ‘through the expertise and leadership of dietitians, it is possible to integrate nutrition into local care pathways (including those for long-term conditions) for all community health and social care settings. It costs more not to treat malnutrition than to treat malnutrition and it is essential that the correct dietetic involvement is accessed locally to ensure the implementation of an evidence-based malnutrition pathway’.

**Hospitals rarely record malnutrition as a primary reason for admission, with primary causes such as disease, illness, injury, or infection often being diagnosed. Even so, figures from the House of Commons Library show that the number of people aged 60 and over whose primary diagnosis was malnutrition, more than trebled in the decade between 2005-06 and 2015-16; from 283, to 921.**

However, the evidence we have received suggests that even these data do not in any way adequately capture the full extent of the problem. Older people are classified upon entering hospital by the immediate cause of their injury or ill health, such as a fall or another accident, but the data do not tell us how influential malnutrition may have been, in weakening their body and

**mind, as a factor which led to that fall or accident.**

**We believe that in an attempt to limit the risk of injury or ill health associated with malnutrition, robust and reliable screening tools must be scaled up across the country so that malnutrition can be identified, diagnosed, and treated much more quickly and effectively in the community.**

**We call on the Secretary of State for Health and Social Care to ensure that at all levels of care, staff are trained to use the Malnutrition Universal Screening Tool, or an equivalent mechanism, to identify older people who are at risk of malnutrition and ensure they receive appropriate food and support to improve their condition.**

## **Chapter 2 – What are the underlying causes of hunger and malnutrition amongst older people?**

### **Medical and physical causes**

Age UK reported to us that medical or disease-related causes of malnutrition centre upon: ill health where the condition, or medication, leads to nausea, weight loss, or a reduction in appetite; 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 swallowing difficulties.

Similarly, physical or disability-related factors can leave older people exposed to malnutrition – pain, loose teeth or denture problems can prevent people eating well. In addition, arthritis, sight loss or limited mobility, can also make it difficult for someone to get to the shops, prepare and cook food or eat independently.

### **An accumulation of setbacks**

**The evidence we have received suggests that malnutrition is most likely to arise amongst older people following an accumulation of setbacks – bereavement, illness, a loss of community transport services, and a nearby shop closing, for example – which leave them unable easily to access food.**

Wendy Wills, Director at the Centre for Research in Primary and Community Care, set out in oral evidence the critical impact an accumulation of setbacks can have on older people's exposure to malnutrition:

'Whereas somebody slightly younger might be able to deal with one or two adverse factors, the older you get [the more] those things

work against you – whether it's bereavement, changes in household situation, changes in income, changes in community transport, not being able to drive anymore, not being able to access the shops when you get there because they feel too big to walk around or they're overwhelming, sometimes with no toilets, or parking is too far from the shop. All of these things build up and result in older people not being able to access the food that they would have been able to in the past. It's that accumulation'.

Michelle Carruthers of The Food Train similarly recorded, 'the incremental difficulties impacted by: bereavement, reduced mobility, reduction in local community based shopping options, reduced public transport, gradually reducing appetite and social isolation', while FoodCycle noted that, 'older guests have multiple challenges, and many of [them tick] multiple boxes, such as long-term health condition, living alone and on a low income'.

A key finding shared with us by Ed Hodson of Citizens Advice Coventry was that, "elderly recipients [of food aid] are more likely to suffer food crisis because of an accumulated poverty rather than the one-off money crisis that younger clients predominantly tend to suffer from'.

Indeed, the Soil Association told us in written evidence that:

'On the face of it, many of the older people we spoke to were coping well. However, it was clear that a slight change in circumstances, such as loss of driving licence, can have a dramatic impact on their ability to cope at home and maintain their independence. This was even worse for those who didn't have any family nearby to help them. Some were having difficulty adapting to home life after a long stay in hospital, which has been complicated by having family and friends that they needed to care for. For

many, the support networks around them were very fragile’.

Evidence from community groups in Swansea produced a comprehensive list of factors which could accumulate, thereby exposing older people to malnutrition: lack of appetite; dementia; forgetting to eat; swallowing issues (dysphagia); dentition; taste changes; lack of motivation or interest in eating; depression; staying in bed longer; living alone and lacking the will or ability to cook for one person; a lack of support from family, friends, or carers, including lacking encouragement to eat where motivation is low (e.g. if the domiciliary care call is restricted in length); poor mobility; or a lack of funds.

Similarly, the Caia Park Partnership Older People’s Day Centre, in a submission presented to us by Ian Lucas MP, concluded that:

‘Problems around hunger [...] tend to stem from bereavement, a deterioration in both physical/mental health and isolation. People who live alone often fall into the mind set of “I can’t be bothered to cook for myself” or are physically unable to stand long enough to prepare meals. We have recently been involved with a lady whose health deteriorated to the extent that she was no longer able to go out to get shopping. It was only when neighbours reported her behaviours as being aggressive and uncharacteristic that the emergency services and ourselves became involved. She was found to be severely underweight and was eventually hospitalised. Access to shopping schemes for the elderly and also the provision of a modern day meals-on-wheels service would I feel go a long way to combating (unnecessary) hunger in older people’.

Two examples shared with us by The Food Train provided a blow-by-blow account of this accumulation of setbacks:

- James, an 82-year-old man described how following his wife’s death he became socially isolated. Two years after this the local shop closed and he needed to get into town – just seven miles away – but the bus service was reduced to just one per day, five days per week. He became anxious about being able to go to the shops, complete his shopping and get home due to reduced mobility. James walks with a stick and cannot rush for a bus. He became reliant on his closest neighbour, also of advanced age, but with some family support to obtain basic groceries for him. His neighbour moved to live with his family and James had no access to food until The Food Train became his only visitor, delivering groceries.
- Claire was a district nurse until retirement. She was well educated about healthy eating and enjoyed cooking. When she was 79 she became depressed after her best friend died. She had lost her partner at 70 and regularly met with her friend for lunch and outings. Claire had sarcopenia, an age related, involuntary loss of skeletal muscle mass and strength, she fell at home and was briefly admitted to hospital. Whilst there she had no visitors and this further impacted upon her mental health. As well as feeling unwell, she ate very little while she was there. When she returned home she had lost so much weight she needed care. Claire was referred to The Food Train for grocery deliveries but her reduced mobility meant she had difficulty cooking and her health deteriorated rapidly. She became a long term in-patient in hospital and subsequently moved into a residential

home. There was no other service available for Claire, no meals on wheels, insufficient home care, no community lunch clubs or transport options available.

The Food Train added that, 'Claire and James were lonely. As with many of our customers they are bereaved, their partners and friends die, they live in rural and urban areas, they often have no visitors, family members often have to move away for work, it becomes harder to get out of the house, public transport becomes too challenging, they may need to walk some distance to a bus stop, they cannot rush for the one bus and if they miss it they have no means to get into town that day. They worry about moving easily in shops, find it difficult to carry groceries, if they want fresh produce they need to shop regularly. People become too anxious to go out and public services are so challenged, they do not become aware of the risk factors or cannot act until the situation is critical and health has deteriorated to such an extent, hospitalisation is inevitable'.

Looking in particular at older people's ability to access supermarkets, the Centre for Research in Primary and Community Care reported how:

'Many of the challenges could be perceived to be relatively small, especially when it came to supermarket shopping. Those identified included: the location of car parking, availability of a suitable toilet, the distance people needed to walk around a store to gather their provisions, obstacles blocking supermarket aisles, a long wait for a bus, having to search for items in suitable package sizes, being unable to read food labels including sell by and use by dates.

'However, the key factor with these often small challenges, perceived by study participants as 'ordinary' or mundane, was the

way that these could accumulate, in some cases to such an extent that someone could no longer face or undertake a shopping trip to the supermarket – so called 'cumulative trivia' or 'daily hassles'.

'Vulnerability can be viewed, as an accumulation of threats (everyday events as well as major catastrophic events) that outstrip resources/assets/resilience of older people, and ultimately result in food insecurity.

'The accessibility of supermarkets (particularly out-of-town stores) was an issue for many older people. This became more of a problem if people had to stop driving because of dementia or failing eyesight, for example, or if the use of public transport turned into a struggle due to declining mobility'.

**Over and above these cumulative setbacks, the evidence we received crystallised around three underlying causes of malnutrition: loneliness and social isolation, the diminished availability of Meals on Wheels, and inadequate social care packages.**

#### Loneliness and social isolation

Much of the evidence we received pinpointed loneliness and isolation – linked with limited mobility and poor access to food – as two of the most prominent causes of malnutrition amongst older people. As the Brighton and Hove Food Partnership put it, 'anyone with health or mobility issues is going to find it harder to access food whether that is shops, support options such as lunch clubs or shared meals, or food banks'.

The Church Urban Fund reported to us that, 'conversations with three of our workers who are directly involved with a range of initiatives responding to household food insecurity in different parts of the country suggested that

loneliness and isolation were far greater problems amongst older people than food poverty, and that this was what the many lunch clubs and similar activities offered by churches and community groups were responding to: the need for conviviality, and in some cases a physically, as well as emotionally, warm space rather than the need for food that one could not otherwise afford.

‘Anecdotal evidence from our Development Workers suggests that physical frailty and the loss of motivation to cook are more significant causes of malnutrition or hunger amongst older people than financial poverty. Difficulty leaving the house, for example, may make it difficult to purchase food, particularly if an older person has limited support from family or friends locally. It was also suggested that poor nutrition was often a problem for older people who had been discharged from hospital with little support in place or limited social networks’.

Picking up on the issue of poor mobility, Sandra Simmons of Birkenhead outlined in written evidence the link between social isolation and:

‘[...] isolation due to mobility problems resulting in loss of confidence, reduction in ability to access local transport added to by difficulties carrying items and also due to distance to any shops selling suitable foods. Having had the experience of looking into a cupboard and fridge of an older person recently, and finding nothing of any substance, I can verify that this is reality, as what was there would not have fed any person for even one meal and there was nothing nourishing within the property. These happenings, if they come to the attention of those working in social care, only do so when things reach crisis point which is happening far more regularly’.

Michelle Carruthers of The Food Train identified how this problem is particularly acute in rural areas: ‘we’ve had people whose one convenience store in their village has stopped selling fruit and vegetables so they can sell more cigarettes and alcohol; meaning a 40-mile journey just to buy fruit and vegetables because there is nothing in rural areas’.

In similar vein, the Caia Park Partnership Older People’s Day Centre, in a submission presented to us by Ian Lucas MP noted:

‘There are many more people in remote areas where the issues are made harder when you add lack of mobility to the equation. No longer is there the local village shop with someone who can deliver food. Now it is expected that if you are not able to get out, that you have the option to shop online, but as we all know there are many of the older generation that would not be in a position to use a computer and set up online shopping’.

This latter point was picked up by Sandra Simmons:

‘Many older people do not have the ability or resources to access online shopping and so are unable to have food delivered to their home. For those who do have the necessary skills and resources the minimum spending limit is too high for their budgetary needs. Additionally in these circumstance the occurrence of forgetting some essential item, [which] results in having to do another shop with another minimum spend of £35 plus delivery costs, is distressing to say the least’.

Of particular importance here is the availability of bus services upon which older people rely to access food. The Centre for Research in Primary and Community Care at the University of Hertfordshire set out in written evidence how:

‘Cuts to bus services have a significant impact, in some cases forcing older people to change the supermarket they shop at regularly despite preferring a competitor. Some supermarkets offered transport, but when available, it may not meet people’s needs, as the time allowed for shopping – typically one hour – is insufficient for many older people to get around a large supermarket. This suggests that, if financially viable, some form of sponsoring of key local bus services by supermarkets could have a positive impact on communities and represent an advantageous publicity and advertising opportunity for the retailer involved’.

Moreover, the submission from Lucy Antal noted how, ‘current approaches to transport, planning and provision of community services may have unintended consequences for food access for older people.’

Tim Ansell of Whitefriars Housing in Coventry, meanwhile, reported that, ‘none of the 11 older person’s schemes that I manage are within reasonable walking distance of a supermarket although all have local convenience type shops nearby. The issue then faced is that the variety of products available is limited with the cost of those products being higher, in particular the availability of reasonable priced fresh fruit and veg is often limited. Additionally a single person may not wish to purchase a pack of tomatoes or 3 courgettes etc., as it is likely that they will not use them all and much ends up as waste’.

### The diminished availability of Meals on Wheels

The evidence we received suggests that the diminished availability of Meals on Wheels services in some parts of the country is increasing the risk of malnutrition amongst older people.

Wendy Wills and Dr Angela Dickinson shared with us a piece of research which identified strong evidence that, ‘Meals on Wheels improves the nutritional status of service users, including quality of diet, nutrient intake, and reducing food insecurity [...] other benefits of the Meals on Wheels service identified by respondents included the additional support provided by the service. Almost half of respondents (46.8%) said that those delivering the food made them a drink, 29.8% said the food was served to them and 82.9% said that they had a conversation’.

Feeding Britain reported that, ‘Meals on Wheels services have traditionally been on the frontline of supporting vulnerable older people, both through the food itself and the social interaction and reassurance of having a regular daily visit. The loss of these services in many local authority areas has a significant impact on older people. We have heard of some councils technically fulfilling their responsibilities by signposting older people to local takeaways or supermarket ready meals’.

Moreover, Sarah Wren of the Hertfordshire Independent Living Service noted in oral evidence how, ‘older people are starving in their homes. Some local authorities have replaced meals on wheels services with a link on their website to takeaway businesses. As if, on any level, that is appropriate?’

The Service added in written evidence that, ‘unfortunately as older and vulnerable people who require Meals on Wheels and other food related support are rarely able to engage in on-line consultations, many local authorities have been able to axe services without any obvious opposition. In our experience, this has often been the culmination of a deliberate down-sizing of meal services (first limiting access to only the most chronically sick and disabled, causing unit costs to increase, and demand to reduce further)’.



Similarly, Sandra Simmons of Birkenhead reported that, 'we have a situation in which even if an elder person were to have their needs recognised and there was a recognition of the need for provision of nourishing food this may not be addressed. Meals on Wheels services which have been supported by local authorities and charity are having to cut back on this provision and when it is maintained it is severely restricted in areas where it still exists'.

Ms Wren added that, 'where Meals on Wheels have been cut, health and social care costs are starting to go up – people are having more falls, more UTIs. It's so obvious that if you don't do the basic stuff, costs are going to go up elsewhere. But until it's reinforced again, until you say, "this is your statutory responsibility", they are not going to do it'.

One example presented to us by Ian Lucas MP, on behalf of the Caia Park Partnership Older People's Day Centre, was of 'a family in the Trevor area. They were not serviced by Meals on Wheels and they were not in a position to be able to afford the alternative companies which deliver cooked meals'.

Figures from the House of Commons Library suggest that in England, gross expenditure on Meals on Wheels more than halved in the decade between 2003-04 and 2013-14; from £96 million, to £42 million. Likewise, the number of older people in receipt of Meals on Wheels services declined by four fifths between 2005-06 and 2013-14; from 155,000, to 29,000. The Library informs us that changes in the reporting of adult social care expenditure mean that Meals on Wheels no longer appears as a discrete category in expenditure publications.

According to Sustain, fewer than half (48%) of local authorities now provide Meals on Wheels services, down from 66% in 2011.

### Inadequate social care packages

Of major concern to us is the heightened risk of malnutrition among older people who either do not receive formal social care, or whose care packages do not include the provision of hot meals.

Sarah Wren of the Hertfordshire Independent Living Service explained in oral evidence that:

'We're getting to the point where health and social care are saying, "we're only going to do it if it is statutory. Feeding has got nothing to do with us". Even in social care, where they're saying, "okay, if somebody needs help to eat, we will help them eat. But if they haven't got the right food in the house, that isn't our problem". It's crazy. It's so simple to deal with some of the big expenses that are hitting health and social care if we just get food into people's homes and provide them with the support they need to stay well for longer'.

We also heard in oral evidence from Michelle Carruthers of The Food Train, how:

'People are maybe on three cold meals a day through a formal care package: a bowl of cereal in the morning, a sandwich at lunch and a sandwich for your dinner – 800 or 900 calories a day – or maybe a microwave meal, if you're lucky. It's because they're rationing care [...] The carer writes at the next visit, "Didn't eat, loss of appetite", but they're just sick of looking at the same sandwiches and they want a good bowl of soup with some bread, maybe some rice pudding and fruit. Every bit of evidence we've got from 22 years shows that if you spend time with an older person, help and support them, they will eat more, they will eat better, and they will continue to do so if you keep that support in place.'

We heard likewise from Sandra Simmons of Birkenhead that, 'when social care do allocate

a home care service to older people the time limited to visits does not allow for purchase and preparation of meals in most areas’.

Ms Carruthers developed this point in written evidence:

‘Food is not provided for older people in the community at the time and point of need. This is the simple truth driving hunger and malnutrition amongst older people [...] Where the Meals on Wheels service is provided this is generally limited to one meal per day at most, but can be less, paid on delivery with restricted menus, deliveries unavailable at weekends, bank holidays and so leaving those with no family support unable to access a meal. If an older person cannot access their funds due to mobility or poor weather they cannot pay for this delivery. If they are not hungry when the meal arrives, for example: lunch arriving at 11am, there is limited capacity to change this time or reheat the meal. We are seeing the consequences of decades of reduced social care funding and community care which brings us to a UK where the resurgence of Scurvy is little more than a soundbite’.

In addition, evidence from Wales set out the example of one older man who, ‘was allocated carers to visit, but when we went there found that the limited amount of food he had was out of date, we replaced the basics, but discovered that there is limited time that people can spend with their client and whereas in years before would have had time to maybe make a butty and check the dates on milk etc., that they had just enough time to look at medication and generally check that he was still alive’.

Loneliness accompanied by a bowl of cereal and two sandwiches, every day, every week, should be unacceptable in modern Britain. But within the current legislative framework, it is almost inevitable.

Section 2 of The Chronically Sick and Disabled Persons Act 1970 requires ‘the provision of meals for [a] person whether in his home or elsewhere’, in cases where a local authority is ‘satisfied’ that ‘it is necessary in order to meet the needs’ of a person with such a service. However, this does not require the food to be hot, nor for other causes of malnutrition to be addressed. In fact, one carer in Wirral who went beyond the call of duty, using their break periods to cook hot meals for older people, was told that they were taking too long and should revert to a bare minimum service.

It was suggested to us in evidence that a clear duty is required for social care providers to ensure nutritious meals are provided to older, frail, disabled, or otherwise vulnerable people who cannot meet their nutritional needs without such support. We return to this suggestion in Chapter 5.

### **Chapter 3 – What is the cost to the National Health Service of hunger and malnutrition amongst older people?**

**Malnutrition amongst older people delivers not only human misery, but also a large and growing bill to the NHS and social care services.**

**Based on a House of Commons Library analysis of BAPEN figures from 2011, we estimate the total annual cost to our country's health and social care services of malnutrition amongst older people to be £11.9 billion. We estimate also that this sum will increase to £13 billion in 2020, and again to £15.7 billion by 2030.**

**The evidence presented to us suggests that the increased direct and indirect costs associated with malnutrition arise from more frequent admissions to hospital, longer stays in hospital, and a greater occurrence of ill health which necessitates visits to GP surgeries. Malnutrition has a severe impact not only on older people's general health, but also on their ability to recover from injury or ill health – bones and muscles in malnourished bodies are more easily damaged and take longer to heal.**

A key finding here is that malnutrition weakens older people's ability to fend off infection and ill health, and increases their likelihood of falling or suffering another accident which leads to extended periods of time in hospital. According to Managing Adult Malnutrition in the Community, 'the clinical consequences of malnutrition are varied and include: impaired immune response; reduced muscle strength and frailty; impaired wound healing; impaired psycho-social function; increased falls risk; impaired recovery from illness and surgery; and poorer clinical outcomes'.

Michelle Carruthers of The Food Train developed this point in oral evidence:

'They are spending masses on unscheduled bed days, particularly for the over-75s, on things that are related to malnutrition: sarcopenia, muscle wastage, and falls. If you start at the beginning of 'what led to that admission in the first place', it is more than likely something as simple as a gradual two or three month decline that has involved not getting enough to eat. The cost of a fall alone is massive'.

Moreover, evidence from community projects in Swansea recorded that, 'malnourished people are more likely to be admitted to long term care. People at high risk of malnutrition are also more likely to be reliant on nutritional supplements which will have an additional cost. Care home residents with eating problems are highly predictive of other negative outcomes, increased health and support needs and accelerated mortality'.

The upshot of this, according to the Malnutrition Task Force, is that treating someone who is malnourished is approximately three times more expensive than for someone who is not malnourished – estimated health and social care expenditure per capita of the population is around £2,500; for those malnourished or at risk of malnutrition, the expenditure rises to around £7,500 per person in the population.

Michelle Carruthers argued in written evidence that, 'astronomical costs can be reduced by having the foresight to fund proven community services [...] community based solutions could prevent early admission into care, reduce malnutrition related deaths and reduce hospital stays. In addition, the longer someone stays in their own homes, supported in the community the more optimal the health outcomes'.

Ms Carruthers also emphasised in oral evidence the need for a stronger focus on preventing ill health through the provision of community food services: 'Unscheduled bed days, unplanned admissions with urine infections on a Friday night, that could have been really stopped throughout the week with additional care support – making sure somebody gets a drink, that they have snacks in between, and so on'.

Looking elsewhere in the system, Brighton and Hove Food Partnership identified, 'hospital discharge [as] a key time to eat well but structural difficulties with the process and sheer workload at the hospital front line means that in reality food slips down the agenda. This is a false economy. Likewise, the lack of priority means that Meals on Wheels are no longer provided by the local authority, as in most other places. This is also a false economy'.

Meanwhile, Sarah Wren of the Hertfordshire Independent Living Service pointed out in oral evidence that, 'prevention doesn't have to be expensive. Our local authority will invest slightly more than the cost of one night's hospital stay, in keeping someone well-nourished for a whole year. So that's 365 days of the year, for the cost of £500 for one night's stay in hospital [...] we see remarkable impacts just by giving people enough calories. There is this great fallacy which almost everyone believes, that it is normal to lose weight when you get old. Of course, it's not'.

Similarly, Ms Carruthers said how, 'we were able to demonstrate over a significant number of years that if you did this, the two direct impacts were fewer older people in care homes and less contact with social work – low-level care was not needed. In one area, one of the unintended consequences was their poorly up-taken frozen meals service that wasn't liked could be done away with, as they could get everything they needed and

more through the shopping services, supported by volunteers, and reported eating better.

'We need to work to help people stay in their own homes, we need to provide food, support cooking and company before people become depressed, before they have an age-related fall, before they become housebound and in recognition that aging is inevitable as are the health consequences but, in our still affluent society starving for attention and food shouldn't be a consequence of aging'.

**We believe that targeted investment in services which protect older people from malnutrition would deliver significant annual savings to the NHS, not least by reducing the number of hospital admissions and limiting the number of days older people spend in hospital.**

#### **Chapter 4 – What range of schemes exists to protect older people from hunger and malnutrition?**

Much of the effort that goes into protecting older people from malnutrition is, as was put to us by Ed Hodson of Citizens Advice Coventry, ‘informal, personal, community focused and ever changing.’

Feeding Britain set out in its written submission four main types of initiative which seek to protect older people from hunger and malnutrition:

- Community cafes that operate on a ‘pay as you feel’ basis or with highly subsidised prices, such as Sarah’s Flowers and Tea in Barnsley. This café makes use of surplus food, and offers a daily lunch for £1, open to all. It offers a welcoming environment where people of all ages can have an affordable meal, and can also enjoy a social space, without any sense of stigma.
- The Home Cooks project in Lambeth, which connects local volunteers with an older person in their community. The volunteer cooks an additional portion of the home cooked meal they are preparing for their own family, and delivers it to the older person. Anecdotal evidence suggests that an older person is more likely to make the effort to eat if the meal has been prepared and offered to them by others.
- Lunch clubs for older people, which provide a social space as well as food. The Centre for Research in Primary and Community Care at the University of Hertfordshire reported that lunch groups provide older people with important opportunities

for social interaction, as well as food, with the social aspects being as, if not more important to them than the food. Likewise, FoodCycle observed how lunch clubs can give bereaved older people ‘something to get out of bed for [...] and go and meet people’. Although some people struggle to access groups if transport provision has been cut, Age UK Brighton and Hove, in a submission presented to us by Caroline Lucas MP, recorded how, ‘community projects and shared meals are proving popular; they encourage healthy eating and help reduce loneliness and isolation’.

- Mobile delivery schemes which, through regular home visits, address mobility and transport barriers. Organisations within the Feeding Bristol network have piloted mobile food banks, and Feeding Derbyshire has trialled affordable food boxes for home delivery.

A notable example of mobile delivery through regular home visits was presented in the form of the Hertfordshire Independent Living Service which, having been set up in 2007, is now the largest not-for-profit charitable social enterprise providing meals on wheels and independent living support in Britain, 365 days a year. Annually, the Service provides around 500,000 hot lunch time meals to around 4,000 older, frail, disabled, and vulnerable people in their homes and 1,000 people meeting in lunch club settings in the community. The Service also provides over 50,000 tea and breakfast packs each year to Meals on Wheels clients, ensuring that a full day’s meals are available for individuals who need them.

The local authority contributes approximately £1.90 to the cost of each meal/visit by means of a quarterly contract payment, with customers themselves covering the remainder

of the cost. The equivalent cost for most local authorities for a 15-minute domiciliary care visit to prepare a lunchtime meal is much higher, at approximately £8.

A similar example is The Food Train, which was established in Scotland 22 years ago as a response to the increasing difficulties certain groups of older people were experiencing in trying to access food. The Food Train's core service involves delivering groceries to 2,720 people each week, with help from 1,075 volunteers. The charity also seeks to provide older people with befriending support as well as social events where there is an opportunity to eat with others. Crucially, volunteers also ensure people's fridges are clean and freezers are defrosted. They also change lightbulbs or adjust clocks, and try to provide help at the time and point of need.

Ed Hodson of Citizens Advice Coventry advocated the provision of additional support for such projects, as opposed to any major national initiatives, because 'grass roots activity designed on a face-to-face personal level, supported by external funds, will work. Local knowledge and a local presence are key'.

Likewise, Feeding Britain said that, 'while we recognise that local authority budgets are under huge pressure, social enterprise models such as HILS can provide a sustainable solution for local authorities, which help to combat hunger and malnutrition, as well as providing reassurance and social interaction for vulnerable older people'.

Indeed, Michelle Carruthers of The Food Train argued that, 'the solution to malnutrition is not complex. We do not need new approaches, we need a national scaling of approaches that are well tested and proven to work. Getting nutritional food to older people is straightforward, the Meals on Wheels service used to provide a comprehensive

range of fresh hot meals to older people, available in the community and publicly funded. Community transport, subsidised travel on regular routes and food as part of care packages used to be available. We need to replace social care provision that was withdrawn, not because of efficacy concerns, but as a cost saving measure. The cost of removing so many community based services is a resurgence of malnutrition among older people.

'Supporting hundreds of customers in this way requires time and effort, building relationships which are enabling, not patronising and most of all listening. Those customers that do receive some kind of care package are supported by workers who may have 7-10 minutes to make a call, there is no time for anything but the most cursory of exchanges. Many of our customers do not have any social care provision. Our staff and volunteers work to bridge this gap.'

**There are some hugely innovative examples of community organisations protecting older people from malnutrition, through either home visiting services or the provision of communal meals. With the right levels of support, those organisations could be scaled up across the country to ensure growing numbers of older people receive the food and support they need, through small acts of kindness, to remain relatively healthy and independent.**

**We are reluctant to call upon the Government, or local authorities, to dig even deeper into their scarce resources to fund new initiatives – as hugely effective as those initiatives may be in countering malnutrition amongst older people. However, we believe that the Government should look carefully at how existing budgets could be**

reallocated among the pensioner population to help safeguard older people from malnutrition.

**We recommend that the Government should consider withdrawing the Winter Fuel Payment from the very richest pensioners in this country and diverting that money to innovative community organisations that seek to protect older people from malnutrition.**

**As an illustrative guide, according to the House of Commons Library:**

- **An additional £5 million a year could be made available for the protection of older people from malnutrition, if the Winter Fuel Payment was no longer paid to pensioners with annual incomes which fall within the additional rate of tax**
- **Alternatively, an additional £100 million a year could be made available, if the Winter Fuel Payment was no longer paid to those with annual incomes which fall within the higher rate of tax**

## **Chapter 5 – What new approaches are required to protect older people from hunger and malnutrition?**

It became clear in the evidence presented to us that malnutrition amongst older people is often intertwined with loneliness and social isolation. It is not surprising, therefore, that suggestions around which new approaches are required to protect older people from malnutrition also advocated the provision of meals as a means of interacting and socialising with other people.

Two new approaches received particular attention in the evidence that was submitted to us: an enhanced home-visiting service through which adequate meals and support are delivered by community projects to those older people who might struggle to leave their own home; and a new role for supermarkets in both maintaining older people's independent shopping habits and providing weekly lunch clubs.

**We recommend that social care providers, including third sector organisations, should be given a duty, and the appropriate funding to carry out this duty, of ensuring all older people at risk of malnutrition, and particularly those in receipt of formal social care, receive at least one hot meal every day with nutritional supplements provided if necessary.**

**We recommend also that through either a more flexible social care package, or the provision of additional support from third sector organisations, this duty should extend to ensuring older people receive the necessary help to prepare that meal and undertake any other brief activities that could, in the longer run, keep malnutrition at bay.**

We focus in this chapter on carving out a new role for supermarkets.

Wendy Wills and Dr Angela Dickinson shared with us in written evidence an estimate that the loss to retailers, by not accommodating older people, could range from £500 million to £4 billion a year. On the flipside, the Centre for Research in Primary and Community Care at the University of Hertfordshire noted that, 'those supermarkets that introduce creative, practical and cost-effective measures that support older people to maintain their shopping can appeal to an increasingly important target market'. Indeed, Dr Dickinson asked in oral evidence, 'why aren't supermarkets more inclusive and supporting older people to continue shopping there?'

Looking at the importance of supermarkets to older people themselves, the Centre added: 'staying in control of their own food shopping is considered key by older people determined to retain their independence and sense of community belonging, and regular trips to the supermarket can ensure older people continue to have access to the food they want to eat.

'For some older people the weekly trip to the supermarket represented the only opportunity for social interaction within the local community. Without it, the risk of isolation rises, in turn increasing the risk of malnutrition'.

Again, expanding on this point in oral evidence, Professor Wills said, 'perhaps it is their only day out of the week, so they don't want to be rushed home as soon as they've done their shopping. Why not serve them at a table, or use the in-store café to bring in other agencies who can talk to people on a certain day of the week so they can have that extra time and support to access their own food while they can?'



### Assisted shopping

One intervention suggested by University of Hertfordshire researchers, which is already gaining momentum, is the introduction of 'slow' or 'relaxed' checkout lanes for older people who prefer to shop at their own pace and not feel hurried, and value the chance to interact with staff or other shoppers.

The Centre for Research in Primary and Community Care at the University of Hertfordshire informed us that Sainsbury's, Marks & Spencer, Tesco and Morrisons are all trialling this scheme in the North East of England. Meanwhile, in Scotland, Morrisons have agreed to trial the scheme in Troon.

The Centre informed us also that a Tesco store in Scotland has introduced a 'relaxed' checkout lane on Tuesday and Wednesday mornings in a scheme supported by Alzheimer's Scotland. Likewise, a Tesco store in Swansea has 'slow' shopping between 1pm and 3pm on Wednesdays with staff trained to be dementia champions by Dementia Voices. The Centre added that while these schemes are appearing at a local level, there does not appear to be a nationally driven initiative by supermarkets' head offices.

As a potential addition to this service, the Centre put forward the idea of 'shopping buddy' schemes at set times of the week, perhaps involving specially trained staff or volunteers helping older people to complete their shopping. Moreover, it was explained to us in evidence that, to enable older people to maintain a decent diet, the availability of appropriate portion sizes is crucial.

### Lunch clubs

A second proposal put to us by the Centre was for supermarkets to use their in-store cafés to bring older people together for hot meals. This could involve organising lunches

for groups of older people, for example, and subsidising community transport for those people at set times each week. We support this idea and believe that those meals should be organised around those times of the week in which 'slow' or 'relaxed' checkout lanes are in operation.

It has not been advocated by anybody that these meals should be free, though, as older people generally do not want to feel as though they are reliant on charitable support and would much prefer to pay.

**We call on Britain's biggest supermarkets to open up a new front in the battle against malnutrition amongst older people. Three reforms, in particular, would move us onto the front foot in this battle:**

- **The provision during set times of the week of assisted shopping, including 'slow' or 'relaxed' checkout lanes, so that older people can continue to shop independently for the food they wish to eat**
- **Accompanying those shopping sessions with a lunch club in the in-store café area**
- **Subsidising the community travel that older people will require to get to the supermarket, both to buy their shopping and to attend the lunch club**

**There is, of course, a hugely important role for each of us as fellow citizens in looking out for our older neighbours. While this does not replace structured support delivered by social care providers, we should all nonetheless recognise our responsibilities to one another.**

## Appendix

We received written evidence from the following individuals and organisations:

1. Age UK
2. Brighton and Hove Food Partnership
3. British Dietetic Association
4. Caroline Lucas MP, on behalf of Age UK Brighton and Hove
5. Centre for Research in Primary and Community Care, University of Hertfordshire
6. Church Urban Fund
7. Ed Hodson, Citizens Advice Coventry
8. Elitsa Yakimov, Co-Director of Chester Pay As You Feel Café
9. Family Fund
10. Feeding Britain
11. Feeding Swansea
12. Food Action Cornwall
13. FoodCycle
14. Hertfordshire Independent Living Service
15. Ian Lucas MP, on behalf of the Caia Park Partnership Older People's Day Centre
16. Lucy Antal, Liverpool Food People
17. Managing Adult Malnutrition in the Community
18. Michelle Carruthers, The Food Train
19. Sandra Simmons
20. Soil Association
21. Sustain
22. Tim Ansell, Whitefriars Housing

An oral evidence session was held on Tuesday 28<sup>th</sup> November 2017 at the House of Commons, in which evidence was taken from Sarah Wren, Hertfordshire Independent Living Service, Michelle Carruthers, The Food Train, and Wendy Wills and Dr Angela Dickinson, Centre for Research in Primary and Community Care, based at the University of Hertfordshire

This report was signed off by Frank Field MP (Chair), Heidi Allen MP, Baroness Jenkin, Emma Lewell-Buck MP, and Philippa Whitford MP.

This report was published on Monday 22<sup>nd</sup> January 2018 by a cross-party group of Members of Parliament and Peers who serve as officers on the All-Party Parliamentary Group on Hunger.

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