BDA The Association of UK Dietitians
Wales Board
Bwrdd Cymru

BDA The Association of UK Dietitians
Older People
Specialist Group

Inquiry into the cost of caring for an ageing population – Consultation Response

1. About the BDA Bwrdd Cymru and BDA Older People Specialist Group

1.1. The British Dietetic Association (BDA) as a whole is a professional body and trade union, founded in 1936, making it one of the oldest and most experienced dietetic organisations in the world.

1.2. The BDA Bwrdd Cymru is the board responsible for representing the professional, educational, public and workplace interests of dietitians in Wales.

1.3. The BDA Older People Specialist Group acts as a forum for the exchange of ideas, information and experience by dietitians working with older people and with an interest in the nutrition of older people.

2. Introduction

2.1. The BDA is grateful for the opportunity to respond to this consultation. In relation to the specific remit of the inquiry, the BDA wishes to raise the following issues:

- The current and future financial pressure on the social care system as a result of malnutrition[1] amongst older people in Wales.
- The demands on dietitians and dietetic support services in social care in Wales.
- To offer the BDA's perspective on the findings and conclusion of the Parliamentary Review.

3. Malnutrition

3.1. Extent and causes of malnutrition

Malnutrition is a problem across the UK and for a range of age groups, but it particularly affects older people. There are estimated to be around 1.3 million people aged over 65 with malnutrition or at risk of malnutrition in the UK, and the vast majority of these are in their own homes in the community – many of them unknown to healthcare services[i].

3.2. Analysis by the British Association of Parenteral and Enteral Nutrition (BAPEN) of data from nutrition screening from 2007-2011[ii] shows that;

- 25-34% of patients admitted to hospital are at risk of malnutrition – of which 80% could have been identified and treated in a community setting
- 30-42% of patients admitted to care homes are at risk of malnutrition

[1] NICE defines a person as malnourished if they have any of the following:

- a BMI of less than 18.5 kg/m^2
- unintentional weight loss greater than 10% within the last 3–6 months
- a BMI of less than 20 kg/m^2 and unintentional weight loss greater than 5% within the last 3–6 months.

- 18-20% of patients admitted to mental health units are at risk of malnutrition

3.3. Malnutrition can have a number of causes, and many cases of malnutrition in older people will be multifaceted.

3.4. Often, malnutrition is disease-related. People with long-term conditions such as kidney disease or chronic lung disease are particularly at risk of malnutrition, as are people with chronic illness such as cancer. Many conditions make it difficult or unpleasant to eat, due to vomiting or diarrhea for example. People with mental illnesses, such as depression, and neurological conditions, such as dementia, are also at greater risk, as they may have reduced appetite, poor mood or a reduced capacity to care for their own wellbeing. Conditions such as Crohn's disease, which disrupt the body's ability to digest food or absorb nutrients also raise the risk of malnutrition.

3.5. Poverty or concerns about affordability are also factors; a report by CEBR for Kellogg's found that on average retired households spend the second highest proportion of gross income on food and drink; 11.2%[iii]. The average annual food bill for a retired household has increased by over 12% from 2012-2017. Indeed, CEBR stated in 2013 that as many as 1.5million over-65s[iv] were in food poverty – defined as spending more than 10% of household income on food.

3.6. Access to food can also be problematic, even when affordability is not an issue. Age UK's Food Shopping in Later Life report highlighted significant numbers of people over 65, and particularly over 80, who struggle to access shops, or have difficulty in-store or with packaging[v]. For elderly people particularly, loneliness and social isolation are a risk factor for malnutrition. According to Age UK, more than two million people over 75 live alone, with many going long periods with little or no social contact[vi].

3.7. Difficulty eating or preparing food for whatever reason is another factor. This can include issues such as swallowing difficulties, mobility issues or problems with teeth or dentures. Even in healthcare settings, people can face problems with accessing food. The latest Adult Inpatient Survey in England (2016)[vii] showed that 17% of patients reported not getting enough help from staff to eat their meals. This figure has improved from 2006, when 21% of patients reported not getting enough help.

3.8. Impact and cost of malnutrition

The impacts on health of malnutrition can be wide ranging, especially amongst elderly people. They include;

- increased risk of illness and infection and slower wound healing
- increased risk of falls
- low mood
- reduced energy levels and muscle strength
- reduced quality of life and independence.

3.9. Data from Marinos Elia's report for BAPEN[viii] on the cost of malnutrition in England in 2011/12 has more recently been extrapolated to the whole of the UK for 2016, in figures presented to the BAPEN Annual Conference. **These figures estimate the cost of malnutrition in Wales to be more than £1.4 billion per annum.** These costs include impacts on all health services, from acute hospital care through to social care in the community.

3.10. We know that older people with malnutrition make much higher use of healthcare services – they are twice as likely to visit their GP and will have more frequent and longer hospital admissions. It also increases their risk of developing co-morbidities[ix].

3.11. Tackling malnutrition

Properly treating malnutrition is a highly cost effective intervention. Nutritional support in adults was ranked as the third highest cost saving intervention (£71,800 per 100,000 general population), associated with implementation of NICE Clinical Guideline (CG32)/Quality Standard (QS24)[x].

3.12. In order to tackle malnutrition we must ensure that everyone has access to a nutritious, high quality diet that meets their individual nutritional requirements and for those unable to meet their nutritional requirements through food alone to have timely access to nutrition support. Systems must be in place in community health and social care settings to identify and support those at risk of a sub-optimal diet and hydration.

3.13. Dietitians play a significant role in the treatment and management of malnutrition in a range of settings. Evidence shows that dietetic care, delivered as part of multidisciplinary approach, is both clinically effective[xi] and cost effective[xii] in the management of malnutrition. Dietitians also have the skills to train other healthcare professionals to identify the risk of malnutrition, and work with a multidisciplinary team to increase nutritional intake and promote weight gain.

3.14. Dietitians should lead the coordinated and integrated approach to addressing the nutritional care of vulnerable populations, including elderly people, in community health and social care settings. Dietetic-led nutrition support services are best placed to develop and initiate the correct evidence-based nutritional care policies and guidelines and ensure that those at risk of malnutrition (whether social or disease-related) are identified and managed appropriately; including those individuals with psycho-social related malnutrition.

3.15. The BDA believes that service commissioners must recognise the value and potential cost savings of preventing malnutrition and therefore commission services that ensure all people identified as being at risk of malnutrition are offered nutrition support interventions that meet personalised nutritional requirements.

3.16. More information on these recommendations is available from the *BDA Policy Statement on the Management of Malnourished Adults in All Community and All Health and Care Settings*[xiii].

4. Demands on Dietetic Services in social care

4.1. As of November 2017, there are approximately 500 registered dietitians in the whole of Wales, spread across acute, primary and community services, as well as public health, industry and freelance roles. Given the scale of the challenge of malnutrition amongst older people alone, the BDA would argue that the number of dietitians needed to ensure appropriate care in both the community and acute sectors must increase if we hope to ensure a good standard of nutrition care amongst the growing ageing population of Wales.

4.2. Our members have reported to us that trusts have recognised a lack of specialist staff available to provide care to Wales' ageing population. For example, Abertawe Bro

Morgannwg UHB has raised specific concerns regarding the services for patients with dementia, and in particular the lack of dietetic provision to the specialist inpatient old age psychiatry department. More generally the health board has placed the nutrition and dietetic workforce in mental health on the board's risk register.

4.3. Nutrition Skills for Life[xiv] is a national programme, run by dietitians, which seeks to equip staff working with vulnerable older adults with the nutrition knowledge and skills to improve food and drink provision for those in their care and prevent malnutrition. This has been very successful, but its delivery continues to be inconsistent across Wales, with some areas having much greater support and access than others.

5. Findings and conclusions of the Parliamentary Review

5.1. The Parliamentary Review published in January 2018 utilises care for older people as an example of how "seamless models of care and support" in Wales might work. It identifies a need for coordinated community, primary and secondary care services with a focus on prevention and early assistance, delivered by multidisciplinary teams of well supported health and care professionals. Dietitians need to be a core part of this, both to help deliver direct interventions and to ensure that the wider health and social care workforce have the skills to prevent, identify and treat malnutrition and other conditions where nutrition is an important factor.

5.2. Such seamless models certainly have the capacity to produce real improvements in patient outcomes while also making better and more efficient use of the NHS's precious resources. However, it will require initial investment and ongoing support of the workforce if it is to happen with the speed and consistency that is required. This is recognised within the Review, but must be backed by the government in its future spending commitments.

[i] http://www.bapen.org.uk/malnutrition-undernutrition/introduction-to-malnutrition?showall=&start=4
[ii] http://www.bapen.org.uk/malnutrition-undernutrition/introduction-to-malnutrition?showall=&start=4
[iii] http://www.manchesterfoodpoverty.co.uk/sites/default/files/Facts%20About%20Food%20Poverty%20Report.pdf
[iv] http://www.itv.com/news/update/2013-12-13/1-5-million-british-pensioners-in-food-poverty/
[v] https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Conferences/Final_Food_Shopping_Report.pdf?dtrk=true
[vi] https://www.nhs.uk/Livewell/women60-plus/Pages/Loneliness-in-older-people.aspx
[vii] http://www.cqc.org.uk/publications/surveys/adult-inpatient-survey-2016
[viii] http://www.bapen.org.uk/resources-and-education/publications-and-reports/malnutrition/cost-of-malnutrition-in-england
[ix] Guest, J. F., Panca, M., Baeyens, J.P., de Man, F., Ljungqvist, O., Pichard, C.,Wait, S and Wilson, L. (2011) Health economic impact of managing patients following a community-based diagnosis of malnutrition in the UK. Clinical Nutrition. 30 (4), 422–429.
[x] https://www.nice.org.uk/guidance/qs24/resources/support-forcommissioners-and-others-using-the-quality-standard-on-nutrition-support-in-adults-252372637
[xi] Baldwin C. and Weekes E (2012) Dietary advice with or without oral nutritional supplements for disease-related malnutrition in adults (Review) [online] Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002008.pub4/pdf [Accessed Nov 2017]
[xii] Collins, J. and Porter, J. (2014) The effect of interventions to prevent and treat malnutrition in patients admitted for rehabilitation: a systematic review with meta-analysis. *J Hum Nutr Diet*.doi: 10.1111/jhn.12230
[xiii] https://www.bda.uk.com/improvinghealth/healthprofessionals/malnutrition_policy_statement_2017
[xiv] https://www.publichealthnetwork.cymru/en/topics/nutrition/nutrition-skills/