Healthy Ageing and Food – bringing a food focus to Brighton & Hove as an 'Age Friendly City'

February 2016 / update June 2016 following further consultation

The aim of this report is to scope the existing work in the city around food and older people and to start identify what an 'Age Friendly City' might look like through the lens of food.

This report has been prepared by the Brighton & Hove Food Partnership (BHFP) for the city's Age Friendly Steering Group and the Brighton & Hove Public Health Commissioner at Brighton and Hove City Council. It has been based on a series of interviews, desk research and workshops. Thank you to everyone who gave their time to talk to us.

The report makes a series of recommendations to inform various bits of work including:

- The 'healthy older people' preventative approach the City Council is developing in relation to commissioning services.
- The actions relating to older people in the city wide Food Poverty Action plan, which the Food Partnership is coordinating along with the City Council.
- The development of neighbourhood hubs
- Progress in delivering the city's food strategy
- Project development / funding bids
- Relatively few Age Friendly Cities focus on food so this scoping exercise may be of interest to other cities nationally and internationally.[1]

The context of this work is Brighton and Hove's ongoing activity to become an ***Age Friendly City*** in line with the approach advocated by the World Health Organisation (WHO). Age Friendly Cities have at their core "the desire and commitment to promote healthy and active ageing and a good quality of life for their older residents"[2]. An underpinning principle is that older people should be seen as active contributors to, not just recipients of services.

[1] A notable exception is Udine in Italy where a quarter of the population are over 65 and against a backdrop of recession an army of volunteers have set about to offer a range of services including food and shopping

2 http://www.who.int/ageing/projects/age_friendly_cities_network/en/

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Process

The background research for this report was put together from March to May 2015, as a deliberately time limited scoping exercise. It was based on desk research, structured interviews, informal conversations and visits to a range of different settings which relate to food and older people in the city. The report is designed to provide an overview and some guidance on future directions - it is not exhaustive and in particular does not pretend to include a full range of voices of older people, though opportunities were taken to consult with older people where possible.

The WHO Active Ageing Policy Framework. The underlying approach to the report has been taken from the WHO Active Ageing policy framework areas, taking a positive 'life course' approach to healthy and active ageing[3]**.** The WHO identifies that good nutrition is important for preventing ill health - especially the impact of chronic disease - in older people[4].

a) **Promoting good health and healthy behaviours** at all ages to prevent or delay the development of chronic disease. Being physically active, **eating a healthy diet**, avoiding the harmful use of alcohol and not smoking or using tobacco products can all reduce the risk of chronic disease in older age. These behaviours need to start in early life and continue into older age.

b) Minimizing the consequences of chronic disease through early detection and quality care (primary, long-term and palliative care). While we can **reduce the risk of chronic disease through a healthy lifestyle**, many people will still develop health problems in older age. We need to **detect** metabolic changes such as high blood pressure, high blood sugar and high cholesterol **early** and **manage them effectively**. But we also need to **address the needs of people who already have chronic disease**, **care for those who can no longer look after themselves** and ensure that everyone can die with dignity.

c) Creating physical and social environments that foster the health and participation of older people. Social determinants not only influence the health behaviours of people across the life course, they are also an important factor in whether older people can continue to participate. It is therefore important to create physical and social environments that are **"age-friendly" and foster the health and participation of older people.**

d) Reinventing ageing – **changing social attitudes to encourage the participation of older people**. Many current attitudes to ageing were developed during the 20th century when there were far fewer older people and when social patterns were very different. These patterns of thinking can limit our capacity to identify the real challenges, and to seize the opportunities, of population ageing in the 21st century. We need to develop new models of ageing that will help us create the future society in which we want to live.

- *A life-course approach to healthy and active ageing - Framework for report taken from Good health adds years to life – briefing for world health day 2012, WHO*

[3] http://whqlibdoc.who.int/hq/2012/WHO_DCO_WHD_2012.2_eng.pdf

[4] "Healthy ageing is a lifelong process. Patterns of harmful behaviour, often established early in life, can reduce the quality of life and even result in premature death. Poor nutrition, physical inactivity, tobacco use and harmful use of alcohol contribute to the development of chronic conditions: 5 of these (diabetes, cardiovascular diseases, cancer, chronic respiratory diseases and mental disorders) account for an estimated 77% of the disease burden and 86% of the deaths in the European Region. The most disadvantaged groups carry the greatest part of this burden." http://www.euro.who.int/en/health-topics/Life-stages/healthy-ageing/data-and-statistics/risk-factors-of-ill-health-among-older-people

A first draft of this report was discussed at a workshop with the Age Friendly City Steering Group on the 8th June 2015 (see Appendix 1 for list of participants) and the recommendations were updated to take into account their feedback. Between July and September 2015 further consultation work was undertaken including a focus group with Age UK's Age Friendly City Forum and at 6 workshops on healthy eating for older people delivered by BHFP. More detail was gathered on the role of the hospital dietetics team in treating malnutrition. This report has been deliberately designed as a scoping exercise. It contains an ambitious mix of principles and practical recommendations.

At the suggestion of the Age Friendly Steering Group the recommendations in the original report on food and dementia were fed back to the CCG commissioner responsible for the city's dementia strategy with the aim of embedding food in strategic wok on dementia rather than having the information within this report. This happened and work to embed food into the city's work on dementia will continue via the newly commissioned dementia alliance and dementia activities services.

In November 2015 Brighton & Hove Council's Neighbourhoods Equalities and Committees Committee and the Board and AGM of the Food Partnership adopted a **Food Poverty Action Plan** for the city taking on board many of the findings and recommendations from this report.

Underlying principles for an Age Friendly 'food' City

From the research and workshop with members of the Age Friendly City Steering Group we have drawn together some underlying principles.

ACCESS TO TASTY, NUTRITIOUS MEALS: Food should be looked at in a holistic way, recognising that meals can be an opportunity to socialise, share and enjoy. Food is vital for good mental health and wellbeing as well as good physical health. Whilst good practice on supplements should be followed (e.g. Vitamin D supplements) and other vitamin intake as recommended by health professionals, in general the vision for a Healthy Ageing City should be that everyone is able to access tasty and nutritious meals.

CHOICE and TASTE: 'Older people' are primarily 'people.' Everyone is different, and people's relationship to food is complex. As with other provision relating to older people, and in a climate of personalised budgets and increasing individual choice, we should avoid 'one size fits all' food answers and recognise people have different cultural traditions, their own styles and preferences, so a range of provision is vital. A Healthy Ageing City should encourage and enable choice.

INNOVATION: There are opportunities especially for the voluntary and community sector to help provide some of these options around food; whether that is adding to existing lunch club provision with new models so that people feel they are 'for them', or developing new methods of delivering cooked meals. There is a danger that if local organisations don't rise to these challenges then choice will be much more restricted to national commercial chains rather than local provision.

A 'LIVING WELL APPROACH': The most effective mechanism is a preventative approach so that people don't become isolated and/or vulnerable to food poverty / a dramatic change in quality of diet in the first place. The limited support available should target times when people are especially vulnerable (e.g. following bereavement and hospital discharge).

OLDER PEOPLE ARE A COMMUNITY RESOURCE: They should be seen as active participants - not passive recipients. A Healthy Ageing City should ensure that opportunities for volunteering are made available and accessible to older people, whether on gardening projects, community lunch clubs or in other settings.

How old is old? Who are these "older people"?

Activities in the city use different definitions of 'older' e.g. some defining 50+ and some 60+. Nutritionists look at a likely shift in nutritional needs at around 75+ but stress that in practice this depends on the individual.

For this report we have chosen to think in terms of the individual as age brackets do not seem to be all that helpful e.g. nutritional guidance would be very different for someone who is overweight compared to someone who is underweight whatever their age; and people's experiences of ageing happen very differently. We have put a focus instead on different settings in relation to older people.

3 different settings this report looks at in relation to older people and food Because this research was undertaken in the context of the Age Friendly City agenda we have been able to consider the needs of all older people not just those with vulnerabilities or people receiving services		
(1)Older people living at home independently Cooking and shopping for self Older people living alone may have particular needs / vulnerabilities	**(2) People supported in their own accommodation** As well as older people themselves, focus for messages is on carers paid and unpaid Informal (partner / family/ neighbour/ volunteer) Formal (paid carers) Sheltered / Seniors housing staff Intermediate care / Independence at Home teams etc Occupational Therapists	**(3) People in a nursing home / residential care setting / hospital** Less control by older people themselves, focus for messages is staff (+ suppliers if meals bought in) Care homes Nursing homes Hospital or rehabilitation Hospice/end of life

This grouping is in order to think in a practical way about where any information or support may need to be targeted. These categories are to help with thinking through the issues, they are not hard and fast, and there is of course overlap between them e.g. someone may be living at home independently but have a small amount of formal or informal care support.

Residential care is not covered in detail in this report, as the 'active ageing' focus is all about a preventive approach to help people to remain well and at home. However, it was felt important that people in residential settings were included as they are a group with the least control over how they eat and a small number of recommendations have also been made regarding this group.

Food and nutrition - and food beyond nutrition

Older People and malnutrition

As people age they may not eat well or get all the energy and nutrients from the food they eat. Whilst in the general population, there is concern about obesity, in relation to older populations there is greater concern about people who are "undernourished" or eating inadequately[5]. Confusingly malnutrition is an umbrella term, which is mainly used for under-nutrition, but can also include over-nutrition and an imbalance of nutrient intake.

Malnutrition is caused by either an inadequate diet, poor appetite or a problem absorbing nutrients from food. There are many reasons why this might happen, including a recent stay in hospital, a long term health condition, lack of mobility, low income, bereavement or social isolation.

As well as impacting on someone's quality of life under-nutrition greatly increases the local and national cost of providing health and social care, as people that are malnourished can experience

- increased ill health
- muscle weakness
- increased length of stay in hospital
- increased risk of infection
- slow recovery after surgery
- poor wound healing
- increased risk of mortality

"Under-nutrition in later life is very common and affects over a million older people. It increases the risk of ill health and infections and can result in a longer recovery time from surgery and illness"

Malnutrition Task Force, 2014[6]

Under-nutrition is often both the cause and consequence of disease and ill health and the contributing factors can be complex and arise for many different reasons. Some of these reasons are associated with ageing itself. A reduced appetite due to less energy expenditure, deterioration in taste and smell (which can be exacerbated by some medications) or eating problems due to difficulty chewing or swallowing will all reduce the enjoyment of food and may lead to a reduction of overall food intake. Illness and medication can impact on the way the body absorbs vitamins and micro-nutrients.

Dehydration is also a common risk, as many older people with diminished appetites or poor nutrition may miss out on their fluid intake from food, therefore need to increase their liquid intake.

[5] More than 3 million people in the UK are either malnourished or at risk of malnutrition at any given time. The majority of these are living in the community, with 5% in care homes and 2% in hospitals (BAPEN, 2012) http://www.bapen.org.uk/professionals/publications-and-resources/commissioning-toolkit

[6] http://www.malnutritiontaskforce.org.uk/wp-content/uploads/2014/07/Prevention_Early_Intervention_Of_Malnutrition_in_Later_Life_Local_community.pdf

What are the other nutritional recommendations?

In the process of this research it became apparent that there is a lot of confusion with regards to nutritional messages for older people. The nutritional requirements of older adults are mainly the same as those for the rest of the population; therefore the general healthy eating recommendations for fat, salt, sugar, carbohydrate and fibre apply. Unless they are at risk of malnutrition, older people should aim to meet all of the evidence based recommendations set by the UK government.[7] There are also, however specific recommendations that need considering:

- Energy requirements decrease with age due to changes in body composition. Muscle mass decreases whilst fat mass increases, resulting in a reduction of basal metabolic rate. Population "Estimated Average Requirements" (EAR) for energy are therefore lower for the 65-74 age group, with a further reduction for those 75 years and over.
- In the UK the majority of people obtain most of their vitamin D through the action of summer sunlight on the skin. However, older people make vitamin D less efficiently, may wear more clothes when they go outside, or may go outside less often due to mobility issues. It has been recommended that everyone considers taking a Vitamin D supplement over the winter months. However, adults over the age of 65 are at **higher risk** of vitamin D deficiency, so are advised to take a supplement of 10ug/day throughout the year. Adults of this age should speak to their GP to discuss the option of vitamin D on prescription. Those in residential care or with darker skin (African, Afro Caribbean or South Asian) have an increased risk of deficiency.

Overweight / obesity

Maintaining a healthy weight throughout the ageing process by eating a healthy, balanced diet and exercising regularly can help in the prevention and management of diabetes and other diseases. It can also reduce the risk of surgery, including routine surgery and improve surgery outcomes.

> ***'My cholesterol is down to 5 from 5.4. My painful joints are much less painful'***
>
> Shape Up Participant

20% of people seen in 2014/15/16 by Brighton & Hove Food Partnership (BHFP)'s Community Nutrition service for one to one and group weight management programmes were aged 55-64 years and 15% were 65 years and over. Older participants are often the ones that report a reduction in a secondary medical condition eg arthritis and medication as a result of the intervention.

Recommendation:

- **BHFP to promote healthy weight programmes in ways that encourage older people to participate and to consider running a specialist Shape Up group for people over 65 yrs old so the dietary advice and activity can be tailored to meet their needs.**

The needs of individuals at either end of the dietary spectrum are relevant

- **Healthier choices -** food that is moderate in salt, sugar, total fat and saturated fat is important for people with diabetes (or at risk of diabetes), people who are overweight, have high cholesterol or high blood pressure.

[7] By COMA in 1991 and the subsequent update by SACN 2001. https://www.gov.uk/government/publications/sacn-dietary-reference-values-for-energy . https://www.gov.uk/government/publications/sacn-update-on-vitamin-d-2007

- **Higher energy -** options are needed for those who require extra calories.

If someone is at risk of under-nutrition they need to eat an energy and nutrient dense diet i.e. choose foods that are higher in fat and protein (for example full fat milk, peanut butter, cream, mayonnaise), a message that does not seem to be widely understood and appreciated.

The Malnutrition Universal Screening Tool (MUST).

Malnutrition is often unrecognised. About 40% of people who are admitted to hospital or care homes are malnourished (BAPEN report, 2008)[8]. Regular screening is the most effective way of ensuring that malnourished individuals can be identified and appropriate action taken. Moreover, effective management of malnutrition will reduce the burden on health and care resources for example from delayed recovery and complications from surgery.

Nutritional screening is a quick, simple procedure that should be undertaken as part of the admission or initial assessment of a person on hospital admission, on arrival in a care setting or if a GP or Practice Nurse has concerns about a person from observations (for example loose fitting rings, reporting lack of appetite, evidence of muscle waste or dental pain/ broken teeth).

It is not clear to the extent to which this tool is being used by staff in care home settings in Brighton & Hove and this question should be part of the review of the training and support needs of care home staff that will be led by the CCG in 2016. A first step would be to undertake a mapping exercise of health and social care settings to understand if / where the MUST tool is / isn't being used.

A concern that was raised during the consultation was that GPs will only screen for malnutrition is a person is ill and that this misses opportunities to spot malnutrition at an early stage and take steps to address this and prevent ill health.

Brighton & Sussex Universities Hospital (BSUH) Quality Account 2013/4 identified that they had failed to reach their own target of improving nutrition screening and treatment rates. They were aiming for 98% compliance with Malnutrition Universal Screening Tool (MUST) but in only 90.5% of the notes reviewed had the patient received a full nutritional review using the MUST score (BSUH Quality Account 2013-14). If a person is highlighted as under-weight using the MUST tool during a visit / stay at BSUH they are referred to the Dietetics team. If they don't get seen a letter is sent to their GP highlighting their MUST score. Performance on this issue has not been reported in the more recent Quality Accounts.

Recommendation:

- **CCG and Adult social Care to review use of the MUST tool in care homes settings, including review of the training and support needs of care home staff**
- **Nutritional screening / MUST tool to be used pro-actively in primary care (ie not just when people are ill) and where malnutrition identified referrals to the Dietetics team made**

[8] www.bapen.org.uk

Self screening

BAPEN (British Association for Parenteral and Enteral Nutrition) is a charitable association that raises awareness of malnutrition and works to advance the nutritional care of patients and those at risk from malnutrition in the wider community. BAPEN raises awareness and understanding of malnutrition in all settings and provides education, advice and resources to advance the nutritional care of patients and those at risk from malnutrition in the wider community.

They have produced a self-screening tool http://www.malnutritionselfscreening.org/self-screening.html to help people concerned that they or a family member are malnourished. They also have a fact-sheet http://www.malnutritionselfscreening.org/pdfs/advice-sheet.pdf. In conversations with organisations that work with older people and carers awareness about these resources was limited.

Where older people should turn for advice / support about nutrition

It became clear during the research that there was a lack of clarity about where older people or their carers should turn to for age appropriate nutritional information or advice if they were concerned about malnutrition. Many people said that they would turn to their GP for advice.

If a GP considers someone to be malnourished they should make a referral to the Dietetics Department at the hospital. People are seen in a weekly outpatient clinic for nutrition support or a home visit can be arranged in more exceptional circumstances.

The Dietetics Department are able to assess the person and identify any other factors that may be contributing to the problem. Treatment will be tailored and if the person is able to eat then the first step will be to support them to address their malnutrition using a food based solution (one that suits their diet and lifestyle) but this can also include food supplements such as Complan or Build Up. The plan will including monitoring to see if treatment goals are being met.

A conversation with a dietician with experience of working in the clinic highlighted that some GPs will automatically prescribe nutritional supplement drinks instead of making a referral to the hospital which means that the opportunity to support the person to address the cause of their malnutrition can get missed.

Recommendation:

- **Need to raise awareness with health / social care professionals about appropriate nutritional information for older people**
- **Identify opportunities to raise awareness on how to spot the signs of malnutrition (for older people, carers and health professionals) and clarify referral pathways**
- **Consider opportunities to provide advice / information about malnutrition in community settings alongside the advice offered by the hospital.**

Training for health, social care and community based staff

In 2013 NICE recommended the use of training (either face to face or e-learning) on nutritional screening using 'MUST' for staff working in hospitals, primary care and care homes to aid implementation on the new NICE Quality Standard for Nutritional Support of Adults: http://guidance.nice.org.uk/QS24

Up until 2106 the Food Partnership's Community Nutrition Team was commissioned to deliver training for support staff on behalf of the Council for 5 years (about 40 people a year come on the courses).

Food and Nutrition for Support staff is an introductory level course and includes portion size, label reading, the Eatwell model and using the malnutrition universal screening tool (MUST). There is a more detailed course for care home staff that covers **meeting individual needs** including dietary implications of common medical conditions including dysphagia and dementia.

Key thoughts and observations from the trainer:

- A surprising number of support staff (working in the community homecare team and residential settings) haven't seen the 'eat well plate' and are not sure of the key nutrition messages if they have
- A high number of staff working with older people are not aware of the MUST tool

There are also in-house training courses run by care agencies and national bodies that provide training in these areas. The co-ordinator of Time for Me Befriending felt that their volunteers would benefit from and be interested in training around food and nutrition for older people and in tips and techniques around using food memories to engage older people.

Recommendation:

- **Establish a unified set of training outcomes for training on nutrition and dehydration across health, community and social care settings to improve quality and consistency of messages.**
- **Roll out training to primary care, hospital teams, frontline staff and volunteers across the system**

Nutrition and the role of meals

A recent study[9] concluded that whilst good nutrition is fundamental to active and healthy ageing, much research into nutrition has focused on what happens if food supplements (e.g. vitamin supplements) are taken, rather than looking at what people actually eat.

> ***"It's such a treat to get food like this…If you're living on a tight pensioner's budget, there just isn't anything left to spend on good food" –***
>
> Hove Methodist Church attendee.

Going beyond nutrition, Brighton & Hove's food strategy[10] and the overall approach of the Brighton & Hove Food Partnership is to emphasise that meals play an important social and cultural function. Research for the Food Partnership's Shared Meals Report'[11] included visiting various settings, where researchers heard that shared meals encourage people to eat more nutritionally. People said how they would not go to the effort of making as many food options/variety of foods if just cooking for themselves. Instead, often people eat a sandwich. This anecdotal evidence supports the current nutritional research; eating with familiar others increases food intake; indeed energy intake increases 18% when eating with friends compared to baseline[12&13].

[9] JRC Science and Policy reports - The Role of Nutrition in Active and Healthy Ageing, Tsz Ning Mak & Sandra Caldeira, 2014
[10] http://bhfood.org.uk/food-strategy
[11] Eating Together: exploring the role of lunch clubs and shared meals in Brighton and Hove, Brighton and Hove Food Partnership 2015
[12] Burke, D; Jennings, M; McClinchy, J; Masey, H; Westwood D; Dickinson A. 2011. 'Community luncheon clubs benefit the nutritional and social wellbeing of free living older people', Journal of Human Nutrition and Dietetics, 24, 277-310.

That food is 'not just nutrition' also came out as a theme in the consultation work with older people including them noting that the dietary preferences for older people are becoming more diverse (eg more Halal, vegetarians, gluten free) a trend that any setting serving food to older people will need to be aware of and respond to.

Recommendation:

- **Promote shared meal settings to people who are at risk of only eating alone**
- **Settings providing food / shared meals should ensure they offer a diverse range of options.**
- **Provide information, recipes and training for volunteers / staff running shared meals projects to help them offer a diverse choice and promote their projects widely**

[13] Wallace, C; Wiggin P. 2007. The Role and Function of Lunch Clubs for Older People, Welsh Assembly Government New Ideas Fund, University of Glamorgan/Concord Associates.

Issues and barriers – food access

1. People living at home

1a Shopping

Being able to shop for food is an important part of staying well and independent. However according to Age UK 19% of people aged 65 or over report they have a longstanding illness that prevents them from shopping or makes it difficult for them.[14]

Living alone in itself can be a barrier. We heard that food is often sold in quantities which are unsuitable for single people on their own, or that smaller quantities are more expensive with people unable to access 'buy one get one free' deals and 'family size' discounts. The preference for purchasing smaller quantities weekly is also a barrier to online shopping for some people, as the delivery cost adds to the cost of food.

Other barriers include age unfriendly packaging, store layout (include height of shelves, deep trolleys and freezers) and lack of rest spaces. Getting to shops was also seen as a barrier in certain areas of the city.

Digital inclusion (access to the internet) is lower amongst older people than in the general population, making it harder to shop without leaving the house and also to find information. Digital inclusion projects should use internet shopping as a practical focus during courses with older people so that people learn how to do it including how to set up 'favourites lists' etc which will help them shop in future. Communications work should take into account different 'levels' of IT confidence for example people may be happy to receive and read information but be less confident about shopping or paying for things online for fear of 'scams'.

1b Cooking for yourself

We heard that whilst many people continue to shop and cook well into older age, others experience barriers such as a change to physical mobility, or a sensory impairment (especially becoming blind). There is however some very good practice around 're-ablement' for example when people have had a stroke there is a service to help them to relearn cooking skills and build confidence, using different methods and equipment.

There is a range of specialist equipment available to help e.g. appliances which have been adapted; and saucepans that are lighter and easier to grip. However it is hard to know if all the people who would benefit are aware of where to get these tools.

> ***"I live on my own. My husband passed away 10 years ago… I'm a widow who doesn't have anyone to cook for"*** – Holland Road Baptist Church attendee

In reality the greatest barrier is that many people simply aren't motivated to cook and eat well if they are eating alone. This feeling can be especially prominent following the loss of a partner. It seems that in contrast with previous comfort and sociability of eating together, food and meal times can exacerbate feelings of isolation for those on their own. An additional practical issue is if the 'lost' partner had been the one who cooked - the remaining partner may not have the skills or confidence to cook for themselves. The 'Old Spice' programme run by the Food Partnership and subsequently picked up by other organisations in the city

[14] Food Shopping in Later Life Age UK (June 2012)

has had some success in reaching older men who have lost partners but provision of this training is patchy. Another successful course has been cooking with a microwave sharing tips and recipes on the wide range of meals that can be cooked in this way.

> ***"We were contacted by the daughter in law of an older man who had lost his wife and was not thriving…. Our carer discovered that he wasn't eating well because he couldn't bear to go into the kitchen. It reminded him too much of his wife. The carer started to go to the shops with him and together they gradually reintroduced cooking. She rang the office excited one day to say that he was peeling carrots in the kitchen and whistling - he had got his mojo back"*** - Local private care agency

We also heard that many people - not just single people - are using ready meals from supermarkets, whether prepared by themselves or heated up by a carer. This seems to be a developing market with Marks & Spencer's recently launching a range aimed at 'mature' customers[15]. Whilst some people are reportedly very happy with ready meals as a staple diet it seems that others are less so. There seems to be little guidance on choosing a ready meal which is nutritionally appropriate, and as with other prepared food there can be concerns about nutritional content, sugar and salt levels[16]. Indeed some of the 'healthy' guidance on ready meals (e.g. 'low fat') might actually be inappropriate for someone at risk of malnutrition who should be looking for high fat or protein alternatives.

Recommendations:

- **Raise awareness of specialist equipment available to help with cooking**
- **Ensure consistent provision of cooking courses eg Old Spice to help people gain confidence to cook for themselves**
- **Develop guidance on choosing nutritionally appropriate ready meals**

2. People supported in their own accommodation

2a. Carers (unpaid family members / friends)

According to the 2011 Census, almost 24,000 people of all ages in Brighton & Hove provide some informal care, much of which will entail looking after older people. Many older people themselves are also carers. The peak age for caring in Brighton & Hove is 50-64 years (25% of people in this age group are carers) although even among people over 85 years, 5% are providing some form of unpaid care.

The national organisation Carers UK acknowledges that nutrition is an important but often hidden issue for carers and their families, with 60% of carers worrying about the nutrition of the person they care for.[17] Caring can be very demanding and may also result in the carer neglecting their own diet due to their caring responsibilities. Carers UK produce guidance for carers on eating well for their own health[18].

[15] http://www.independent.co.uk/life-style/food-and-drink/features/many-elderly-people-turn-to-ready-meals-but-can-they-compete-with-a-proper-dinner-10153295.html
[16] http://news.bbc.co.uk/1/hi/health/3756451.stm
[17] http://www.carersuk.org/help-and-advice/health/nutrition/
[18] http://www.caerphilly.gov.uk/CaerphillyDocs/Adults-and-older-people/Carers/Eating_Well_Leaflet_Carers_UK.aspx

The Shape Up Wellbeing Coach Service (delivered by Albion in the Community) offers carers above an ideal weight one to one support in their own home or a suitable nearby community venue to help them manage diet and exercise.

Practice nurses are responsible for undertaking health checks for both carers and older people's. They need to be well trained in how to identify people who may be neglecting their diet and sign post people to support.

Locally there is very little information about food available for people caring for older people although interviews with the Carers Centre confirmed that shopping and cooking are key roles of carers. They felt that more information, support and advice would be beneficial especially if the focus was on healthy eating on a budget (either at home or at community venues) given the tight financial situation many carers are in, especially carers of pension age who are not entitled to carers allowance. They suggested that printed information would be useful for example a '5 points' fact sheet - not just aimed at carers but also for older people themselves. They also felt that practical tips or demonstrations on skills for shopping / cooking for someone else would be helpful.

Help for carers and older people to be more digitally included to benefit from online food shopping (saving time), was also identified as a gap. This echoes conversations with Age UK that IT training for older people should include tutorials on doing online supermarket shopping and helping people to set up 'favourite item' lists. Carers are also a good route for raising awareness about lunch clubs and other community meal provision and may provide the means of getting people to activities. The network of carers' coffee mornings and meetings provide an opportunity to reach older carers and those that care for older people.

Additionally the importance of respite for carers is well documented and any work on food and carers (of older people and older carers) could consider options for food related respite activities such as those provided by the Carers Centre Allotment or food related carers breaks / 'time for me' sessions.

Recommendations:

- **Train practice nurses how to identify people neglecting their diet and sign post people to support**
- **Digital inclusion training to include how to do online supermarket shopping**
- **Respite offers for carers to include food related activities**
- **Use carers networks (eg Carers Centre) to share information about older people and nutrition including details about shared meal settings**

2b. Paid Care workers

For many older people (and this trend is likely to increase) cooking and shopping are carried out by a paid care worker. There are a number of barriers to healthy meals here, including whether the paid care worker understands the nutritional needs of older people; and whether they have the knowledge and skills to cook. However the primary barrier seems to be the time allowed for visits (which may be as little as 15 minutes) which make it impractical to do much more than heat up a ready meal in a microwave.

The consultation focus group reported that now many people are self-funding and choose from a range of different agencies, it has become more difficult to measure quality and accountability. Engaging with the home care companies was seen to be vital in the success of achieving a vision of an age friendly food city.

Recommendation:

- **Engage home care providers in this work. Any information materials produced should be circulated widely including via paid care agencies.**

2c. Delivered meals/ meals on wheels/ Community Meals

Nationally, the number of people receiving 'Meals on Wheels' has tumbled by over 80% in 10 years. The Malnutrition Task Force reveals that older people are either losing their meals on wheels provision because of local authority budget cuts or face extremely steep price increases, which can make the 'Meals on Wheels' service unaffordable for pensioners living on a low fixed income. If healthy, affordable community meal options are not provided there is a risk that people may end up with health conditions that cost more to treat than the cost of subsidising good food in the first place.

From April 2016 Brighton & Hove City Council changed their Community Meals (Meals on Wheels) provision to one where only a very small number of people receive a paid for service from them (these are people who have relied on Meals on Wheels in the past and have no funds to pay for their own food).

The Council has moved to a 'preferred providers list', so that people in need of a meal are able to choose from a range of different options available to them. The average cost of a meal on the 'preferred providers list' is £6/£7 and the person delivering the food will also provide a 'safe and well check'.

Although we don't have figures, there appears to be much use of private meal delivery services ranging from local takeaways which offer delivery; to companies specifically set up to deliver frozen meals for microwaving e.g. Cook (www.cookfood.net) which has an emphasis on taste / 'home cooked' quality and Wiltshire Farm Foods (www.wiltshirefarmfoods.com), which has an emphasis on nutrition and catering for older customers and special diets e.g. soft, pureed meals and 'reformed' meals where the puree is reshaped to look more appetising. Newhaven firm Brilyn (www.mealsonwheels.uk.com) delivers freshly cooked meals on plates for reheating to residents in the East of the city e.g. Woodingdean and include a 'safe and well' check and cater for special diets. These companies provide food which can be frozen and either open or microwave heated. Average meals costs £4-£6.

The council has made a number of positive commitments around the provision of Community Meals within the city's Food Poverty Action Plan. The new system must include providers that can deliver a hot, nutritious, affordable meal 365-days a year alongside the 'safe and well' check that is so vital to the well-being of those that are vulnerable.

As the city moves towards a system of preferred suppliers there are opportunities to expand the offer to include local provision. It is possible. Fair Meals Direct is a not-for-profit scheme started up in April 2014 when it took over from Cumbria County Council's 'Meals on Wheels' service. The meals are freshly prepared using locally-produced food (under a 30-mile radius of Carlisle) in a previously underused kitchen in a hostel which provides emergency accommodation for families. The residents take part in preparing the food, providing useful kitchen skills that they can take with them and a team of volunteers deliver the meals so the clients get the much-needed social contact as well as a hot meal. This video tells their story.

Elsewhere, in Plymouth the provision of Community Meals moved from Adult Social Care to being provided by their School Meals Team. This successful scheme now provides adults with the same freshly cooked hot meals that the children get at school. Plymouth Community Meals has also been awarded the Soil Association's Food for Life Gold Catering Mark.

Recommendation

- **With the ending of Meals of Wheels it is important that older people are given good information / advice about the range of options to get food in the city and what to look out for when making choices. Provision of this information should be part of care assessments.**
- **New opportunities to join the 'preferred providers' list for Community Meals should be promoted to community based organisations.**

2d. Support from neighbours and networks

There is of course a great deal of informal unrecorded activity from family, friends, neighbours and other communities such as faith groups, where people may provide or share a meal. Nationally franchises such as 'Casserole Club'[19] can act as a bit of a halfway house between informal and more structured community activity, using a web based platform to help "people share extra portions of home-cooked food with others in their area who are not always able to cook for themselves". Locally, Know My Neighbour encourages links at neighbourhood level e.g. Xmas Mince Pie meet up. The Neighbourhood Care scheme and other befriending schemes in the city provide companionship to hundreds of older people. Conversations have started between Impetus, the Brighton & Hove Food Partnership, FutureGov (owners of Casserole Club) and some local digital marketing experts on introducing Casserole Club to Brighton & Hove.

Recommendation:

- **Explore the potential for Casserole Club in Brighton & Hove**

3. Care homes - Healthy Choice Award – Residential Care Settings

The Healthy Choice Award is a joint initiative from the Food Partnership and Brighton & Hove City Council, which looks at meals and snacks offered in breakfast clubs, nurseries and residential care homes. Working together, the aim is to award settings which serve varied, nutritious and age appropriate menus. Further recognition is given through the Healthy Choice Award Gold - to those settings working towards nine key sustainability standards. Residential care homes can receive support and advice on menu planning from the Food Partnership's nutritionist. 15 residential care homes in the city currently have the award (2 Gold) which is only a small proportion of the total number of care homes in the city. There have not been resources to undertake targeted promotion work to these settings in recent years although the award is well received by places that find out about it.

Recommendation:

[19] https://www.casseroleclub.com/

- **Explore the potential for rolling out targeted health promotion work, including around the food agenda, with care homes across the city**

Eating outside the home - lunch club, shared meals and restaurants and cafes

Restaurants and cafes

We heard that many of those who are mobile i.e. have cars or can use buses or who have support with transport, prefer eating outside the home in restaurants and cafes, and that the cost can be comparable to home delivery of meals. There are special OAP meal deals in some settings, which help to keep the prices down. Some people would prefer smaller portions and it was noted that some settings which offer a children's menu won't let older people order from it, even if requested.

For many people retirement means more time and more freedom. One of the messages we repeatedly heard is that older people are primarily people and not everyone wants a special OAP deal or lunch club - they want to eat in places with people of different ages in 'normal' settings.

Recommendation:

- **Explore the potential for working with the restaurant sector to offer smaller portions to older people, along the lines of children's menus**

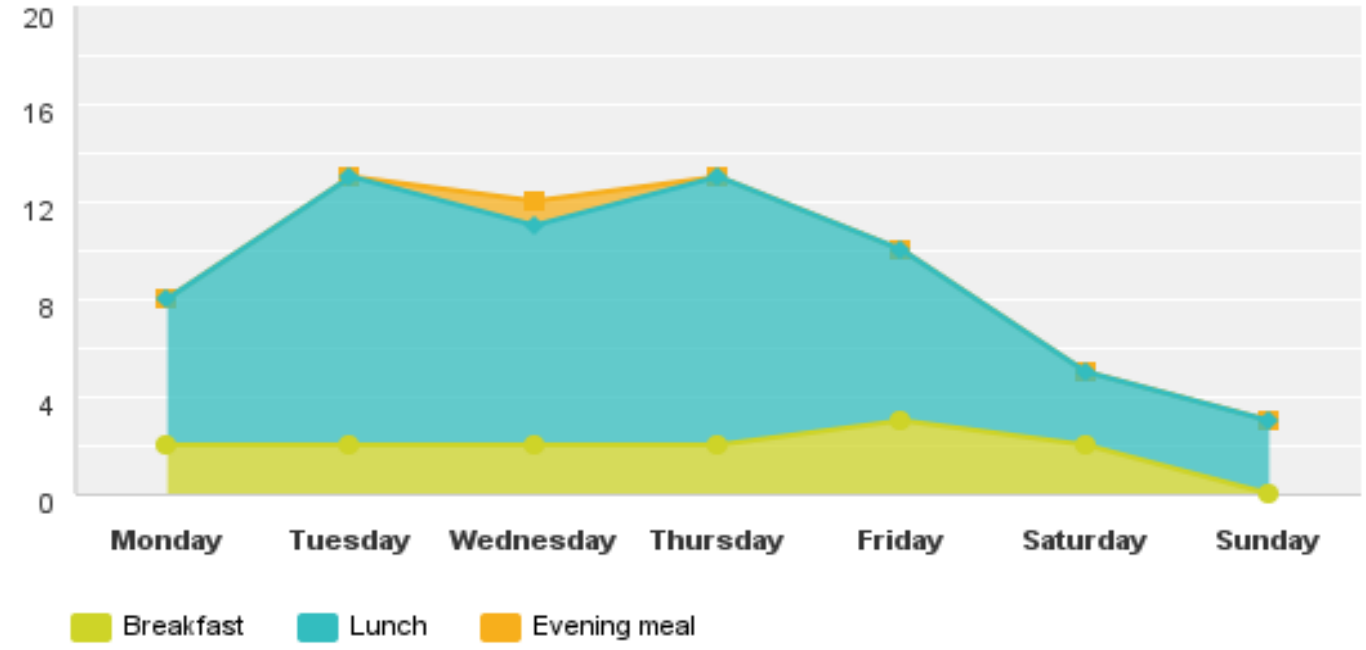
Shared meals

In parallel to this report, the Food Partnership has been exploring the role of 'Shared Meals' in Brighton & Hove. **1,265 shared meals take place each day, or almost half a million a year** and these shared meals play a vital role in the wellbeing of our city's residents, including those who are at greatest risk of isolation, poor nutrition and food poverty. As well as food and company, they nearly all offer support and advice, and often act as a gateway into other services. Shared meals take place in lunch clubs, day centres, and community growing projects and increasingly in private care homes, who are responding to a gap in the market by offering meals for non-residents. There are also shared meals in settings such as seniors housing, where they tend to be resident organised - for example 'fish and chip clubs'. Changes to the way that that social services funding is allocated means that in future more people will receive 'individual budgets' or be entirely self-funding. For some people, so long as they are accessible and there is the right transport and support, '**meals in the community'** options might be preferable to 'community meals' i.e. people might prefer to experience a shared meal such as a lunch club, or a café, pub or restaurant rather than receive a 'meals on wheels' meals package to their home in isolation. We noticed that some people are already 'serial lunch clubbers' visiting a different lunch club on different days of the week in preference to cooking / eating at home. However there are gaps in provision, with lunch clubs in particular running less at weekends.

Local provision was seen to be successful and projects such as the Hangleton and Knoll Project cite their strong links with community as key to success in their food projects. However there is also a significant gap in provision identified in the **North and East** of the city - often in areas where access to shops is also tricky creating a double barrier.

Good Practice Example: In Somerset Day Centre, a local greengrocer takes orders for fresh fruit, vegetables and eggs, which some members find very convenient. This may be a good service to offer in other settings?

Lunch club provision by day of the week and area of the city



Source: http://brighton-hove.communityinsight.org/

Interested parties should note there are gaps in shared meal provision (especially lunch clubs) at weekends and in the East and North of the City. As local provision is the most successful model (52% of people accessing shared meals live nearby) this is likely to be a barrier to access. Additionally groups such as the Hangleton and Knoll project suggest that their community focus and links strengthened their food work, as they knew their neighbourhood well and had effective reach. Opportunities for intergenerational shared meal options for example schools inviting older people to join the school lunch should be considered (School Meals Service) There is also a perception barrier. Although it was hard to get clear data on this, it seemed that a preconception of place might prevent some people from using lunch clubs (It's "not for me"). Alongside more traditional provision of lunch clubs there is potential for other options for meal sharing for example learning from high profile/ social media savvy profile shared meal organisations such as The Real Junk Food Project. Some quite subtle changes of wording (eg changing 'lunch club' to 'shared meal' or 'social meal' and meeting people's 'interests' rather than providing 'activities') might help to do this.

An important finding was that providers are facing an increase in demand which they may lack capacity to meet. For more details on shared meals see the Food Partnership report[20].

Older People as active participants: As with gardening projects (below) older people should be seen as a resource, with skills, wisdom and time to share; rather than as passive service users. Many lunch clubs and shared meal settings rely on older people as volunteers – we saw a whole range of volunteers up to 95 years old, and most reported great satisfaction from their experience of volunteering - "keeping going keeps you going!" It was noted that in particular what people called the 'younger older' - or more active - volunteers play a key role and that this pool may get smaller in future as people have to / or want to keep working for longer.

Recommendation:

- **Explore the potential for addressing the gap in provision of community meals and fresh food provision in the north and east of the city**

Gardening and food growing

There is strong evidence for the physical health benefits of gardening, especially in later life summed up popularly as 'Gardening linked to longer lives'[21] due to the beneficial effects on cardiovascular health. One study suggested being active reduced the likelihood of a heart attack, stroke or angina by 27% and death from any cause by 30%[22].

Locally the evaluation of the Harvest project[23], which was a four year Lottery-funded project to encourage people to grow their own food, offered compelling evidence that, as well as physical

> ***"Older people reported greater benefits from gardening than other respondents. 93% said they gardened to access fruit & veg, 52% did so in order to be physically active, 42% did so to improve their mental health and 24% to meet other people."*** - Harvest evaluation survey

[20] Eating Together: exploring the role of lunch clubs and shared meals in Brighton and Hove, Brighton and Hove Food Partnership 2015
[21] E.g. http://www.bbc.co.uk/news/health-24710089 http://www.express.co.uk/life-style/health/570786/Gardening-key-longer-life-Doctors-prescribe-health-boosting-hobby
[22] http://www.nhs.uk/news/2013/10October/Pages/Can-DIY-and-gardening-help-you-live-longer.aspx
[23] http://bhfood.org.uk/food-strategy

health, gardening is highly beneficial for mental health and wellbeing.

An extensive survey of allotment usage in Brighton & Hove showed that older people, who currently benefit from a discount in allotment rental, rate their allotments particularly highly as contributors to both health and happiness[24].

> ***"An allotment is a 'social service' too and helps to avoid loneliness and isolation, so therefore the cost of the service cannot be estimated in traditional ways"*** - Plot holder survey

In 2014 a survey of 800 plot holders 209 responses were from people over 60. Of these 80% said that having an allotment was important / very important for their health and happiness.

There is also participation by older people in the city's 70+ community gardening projects, either specifically for older people (e.g. in Hangleton and Knoll) or mixed age. Anecdotal reports and observations by Food Partnership staff suggest older people make up a significant proportion of participants at these garden projects.

In 2014 a pilot 'Fit for Gardening' training day organised by Active for Life and the Food Partnership had high interest. Attendees were mainly older people (67% 50-64 yrs old and 17% 65 and over), the majority of whom have long-term health conditions and wanted support to get back into gardening safely. The focus was on stretches to help with things like back pain, aches and pains. Helping people to keep gardening as long as possible means these people continue receiving the physical and mental health benefits that gardening brings.

Reduced mobility can be a barrier. The Food Partnership previously ran a 'Grow Your Neighbour's Own' project which put people who wanted to grow food in touch with people who needed help gardening, but this ceased due to difficult logistics in making matches across a large city (with gardens concentrated on the outskirts and gardeners in the centre). AgeUK Brighton & Hove's 'Help at Home' scheme matches older people with vetted, freelance gardeners that they can pay to maintain their spaces. Brighton & Hove City Council tenants who are over 70 or have a disability can also apply for free gardening help. The allotment strategy includes plans to increase the number of smaller and accessible mini allotments which could help some older people to keep gardening even if a regular plot becomes unmanageable.

Both allotments and community gardens have benefits around reducing isolation and seem to help in building cross-generational communities for mutual benefit, with some participants in the allotment survey noting older people often act as a source of knowledge around growing which is highly prized by younger people.

Participation in food growing has an obvious benefit, in that people are able to access fresh nutritious produce, and in the case of community growing projects, often a shared meal cooked on site. However the food access benefits are almost an 'added extra' compared to the physical and mental health benefits.

The "Growing Health[25]" report takes an evidence-based approach to summarising the health and wellbeing benefits of food growing for different groups and provides a useful summary of relevant studies.

Recommendation:

[24] Brighton & Hove Allotment Strategy 2014-2024, Brighton & Hove City Council & Brighton & Hove Allotment Federation http://www.brighton-hove.gov.uk/content/leisure-and-libraries/parks-and-green-spaces/allotment-strategy-2014-2024

[25] **Growing Health: Food Growing for Health and Wellbeing,** Garden Organic and Sustain, April 2014 www.growinghealth.info

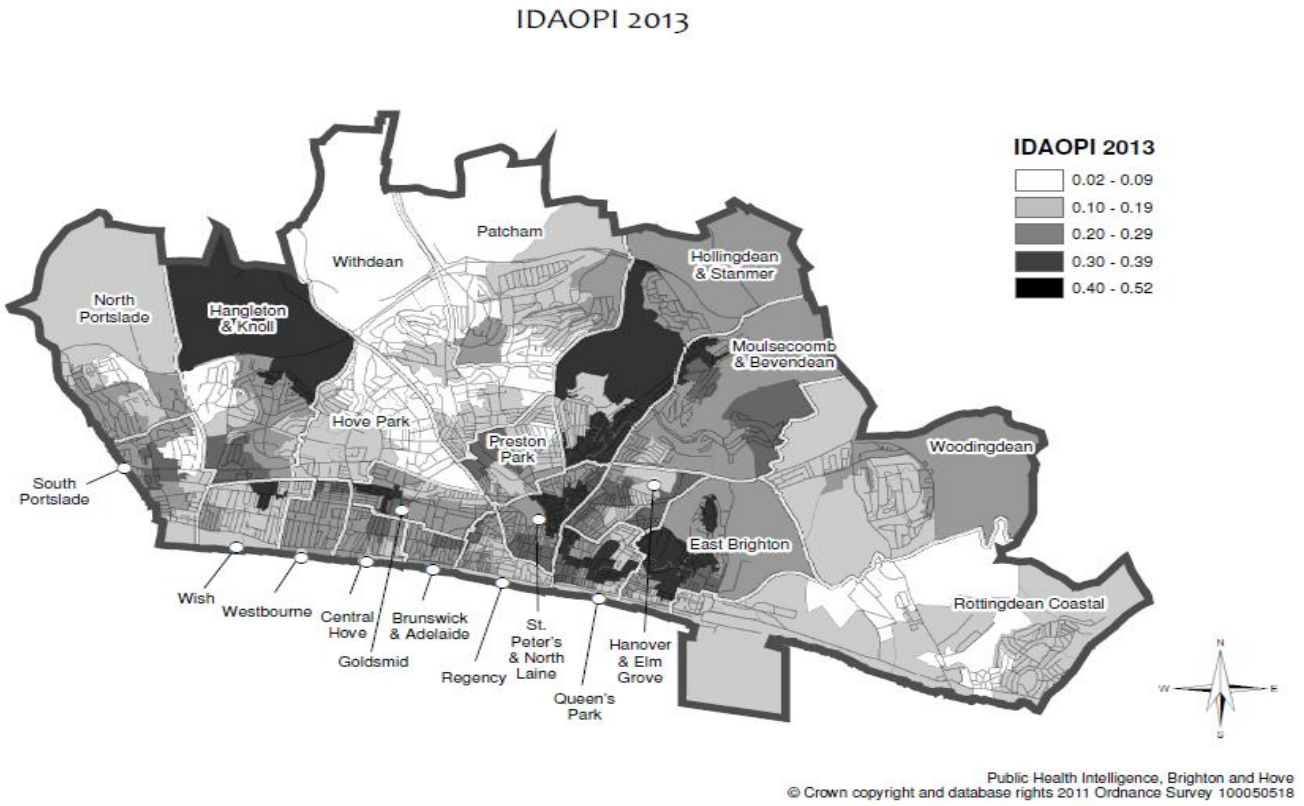
- **A concession rate linked to pensionable age should be retained for allotment rents in the city**
- **Easy access allotment plots should be provided for people with limited mobility**
- **Opportunities to volunteer on community food projects should be promoted to older people**

Food poverty & food access; digital access; transport

Whilst there is no single definition of food poverty, definitions stress that food poverty is about more than hunger and most definitions focus on being able to eat nutritiously, rather than just to eat[26]. It is clear that food poverty is increasing both nationally and in Brighton &Hove, with both the 2014 and 2015 City Tracker surveys showing that nearly a quarter of the city anticipate difficulty paying for food/fuel, with particularly high levels of insecurity for those with a disability or long term health condition.

As people grow older they typically spend an increasing proportion of their income on food, domestic energy bills, housing and council tax; in households headed by someone aged 75 and over this amounts to 40% of their weekly expenditure. This makes them particularly vulnerable to price inflation such as those seen in recent years for food and energy.

The table below illustrates the percentage of adults aged 60 years or over living in income deprived households (IDAOPI).



Food poverty is a complex area and is about more than money. Several interviewees stressed that for many older people the issues may be as much about **food access** as about income. Barriers to eating well include:

- a lack of transport

[26] The evidence review for the **Feeding Britain, the Parliamentary Enquiry into Food Poverty and Hunger** published in December 2014 *selected* this definition: "Food poverty can be defined as the inability to afford, or to have access to, foods which make up a healthy diet. Those experiencing food poverty may have limited money for food after paying for other household expenses; live in areas where food choice is restricted by local availability and lack of transport to large supermarkets; or be lacking in the knowledge, skills or cooking equipment necessary to prepare healthy meals. *Written evidence from the Public Health Nutrition Team, Central London Community Healthcare NHS Trust*. https://foodpovertyinquiry.files.wordpress.com/2014/12/food-poverty-appg-evidence-review-final.pdf

- shops that are not well laid out for accessibility
- limited provision of local shops particularly those selling food ('food deserts') and/or high cost and limited choice of food items in local shops
- 'digital' exclusion or inability to access the internet for shopping
- lack of time for shopping/preparing food e.g. people with extensive caring responsibilities
- access to adapted cooking equipment
- cooking skills

Having said that it is clear that a number of older people are living on a reduced income, in a climate of rising prices [27] and lack of money is a major barrier to eating well for many people. The 'heat or eat' dilemma is a particular issue for older people who may require higher levels of heating for longer in the day.

Food poverty is about much more than money, but having an adequate income in retirement was seen as vital to avoiding food poverty. Therefore Money Advice Services in the city may need to become better at helping people plan retirement / finances in older age. Age UK offer financial / legal advice – demand is growing and they plan to extend this. Advice about planning for retirements should include consideration of food arrangements not just financial planning.

Free bus passes were widely praised, but if people are unable to access buses then taxi fares are relatively high. The Carers Centre raised concerns about any reductions to carers allowance and/or changes to benefits for disabled people that would reduce household incomes.

Some older people may be reluctant - due to perceived stigma or lack of knowledge - to access the welfare benefits they are entitled to. Food banks nationally and locally report low usage by older people, both due to stigma and lack of accessibility.

- Older people's spending decreases as they age, although certain specific areas of expenditure increase, most notably food and non-alcoholic drink (12% to 19%) and housing, fuel, and power (12% to 24%) (Collard & Hayes 2013).
- Almost one in ten 70-74 year olds face difficulties when shopping because of 'a physical, mental, emotional or memory problem', rising to 60% of those aged 90 or over, Atkinson & Hayes 2010.[28]
- The probability of an older consumer making a purchase on the internet declines markedly with age, such that only 23% of 60-64 year olds were found to have made an online purchase in a 12-month period, which reduced to 13% in the 65-69 year old group. [28]

Transport emerged as the key issue for both shopping for ingredients and for accessing cooked food outside the home, especially for those without or with limited access to online shopping options. We noticed that the most popular lunch clubs (50+ attendees) are either on main bus routes (free bus passes play an important role), or provide transport options via arrangements with volunteers, or community transport minibuses or both.

[27] **Feeding Britain, the Parliamentary Enquiry into Food Poverty and Hunger** published in December 2014 shows that food, energy and housing prices have risen disproportionately in the UK to other European countries, and incomes have not kept pace. https://foodpovertyinquiry.files.wordpress.com/2014/12/food-poverty-feeding-britain-final.pdf

[28] Population Ageing & the Voluntary Sector: Key Figures & Projected Trends April 2014 https://cvsanpc.files.wordpress.com/2014/03/population-ageing-the-voluntary-sector-key-figures-projected-trends.pdf

The survey for the 'Shared Meals' report found that:

- ***61%** of projects find **'transport'** the biggest barrier to people accessing the project*
- ***32%** of projects find **'accessibility'** the biggest barrier to people using the project*

Recommendation:

- **Groups should refer to Possability People's (rebranded Federation of Disabled People) 'Out and About' guide for useful examples and guidance on ensuring effective (free) insurance provision for volunteer drivers http://www.thefedonline.org.uk/citywide-connect .**
- **During the research for this report it was identified that people may need help to go shopping if they are to avoid costly local stores. More discussion should take place with partners to establish if there is a need for a food shopping service?**

Additional health factors which need considering

Dementia

Dementia is a major barrier to eating well, and can also be a factor in dehydration. It can lead to changes in food preferences, in particular a liking for sweeter foods, and people who are confused may miss meals, forget to eat or forget they have eaten already, resulting in under or over nutrition. The Alzheimer's Society produces a useful overview and a practical factsheet[29].

People may need specialist eating equipment or support to eat and they (or their carers) may not know how to access this. Additionally, we heard that some people with dementia may have very limited cooking facilities at home if these have been removed because of concerns about safety.

Sensory impairment

This has been mentioned above, noting that blindness can be a barrier in connection with cooking and shopping; and some interviewees also picked this up as a major factor in increasing isolation. Both blindness and deafness can be a barrier to shopping; and to attending community activities such as lunch clubs.

'Entrenched' Isolation

Research demonstrates that loneliness is felt particularly acutely by older people: almost one in ten people aged 65 and over report regularly or always feeling lonely[30]. 41% of people over 65 in Brighton & Hove live on their own - 10% higher than the UK average (Census 2011)

Staff, volunteers and service users in local lunch clubs talked about isolation itself becoming one of the factors in generating isolation. Once people start to get isolated, they can quickly lose confidence in socialising. It is also easy to lose motivation for cooking and eating, and

> ***"I don't get depression now that I come here. I used to just sit at home, between the four walls in front of the telly – same in, same out… Now I come and see my friends every week"*** – Somerset Day Centre attendee

[29] http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=149
[30] Social Exclusion Unit, A Sure Start to Later Life, 2006

quickly become depressed. There can be vicious circle here as good nutrition is vital for good mental health, yet depression can make it hard to cook and eat well. There seems to be a number of people in extreme isolation, not in touch with services or even with anyone, who are in a sense the 'hardest to reach'. Even knowing about these people is a challenge and the 'City Wide Connect' project is engaging police and fire service staff in helping to identify them.

Yet food itself is a way to bring people together, and a number of service users (especially in day centres) stressed that attendance had turned around their depression and transformed their lives. Crucially in a day centre setting this had come about with support - attendance arose via a referral from a doctor or social services, and often with transport provision. Some lunch clubs are working with befriending groups to support very isolated people to attend, and this seems very successful, although currently only reaching a small number of people.

Commissioners and other decision makers should recognise the major but largely unrecognised role that shared meals e.g. lunch clubs are playing in improving the health, nutrition and mental health of the city – tackling isolation, food poverty and acting as a gateway to advice and support - and help ensure that projects can keep up with the increase in demand identified in this report. Cost, access and (especially) transport are key factors in people accessing them

The most effective intervention regarding extreme isolation is to prevent people becoming cut off in the first place. This was a cross cutting theme which emerged from many conversations and it is recommended that commissioners look at ensuring support is targeted at the most vulnerable times (e.g. bereavement and hospital discharge) and good practice elsewhere e.g. in providing 'food bags' for people to take home from hospital, so they are able to eat during the gap before a care package is put in place.

Recommendation:

- **Targeted information and support should be provided at times that people are most vulnerable to becoming socially isolated eg bereavement or following a hospital visit / fall or major illness**

Practical Recommendations / next steps

The recommendations have been grouped together for convenience, but ***please read them in relation to the main body of the report above which outlines the barriers to accessing a healthy diet, and looks at the evidence of what works***. During the consultation on this report and the subsequent work on the food poverty action plan the role of diet in preventing ill health (including life limiting diseases such as Diabetes, cancer and heart disease) and both the human and health care costs associated with diet related ill health was repeatedly mentioned as was the importance of food as a means of achieving wellbeing. This approach chimes with the policy context of the Care Act / Better Care with the focus on person centred care and a preventative approach.

Recommendation 1: Knowledge and Information for older people	**Progress August 2016**
1a) Identify where older people would like to find more information eg as part of health checks, at pharmacies, in newspapers, libraries etc.	Question asked as part of consultation on this work and a survey of older people by Age UK. GPs and Libraries were ID as two key locations
1b) Develop locally relevant printed / web based information that covers information about how nutritional needs change as people age, options to access shared meals in the city, how to spot signs of malnutrition, home delivery, guidance on choosing nutritionally appropriate ready meals and equipment and adaptions that can help with food preparation	BHFP have drafted text waiting for findings of Age UK research to finalise. Will seek funding to produce and circulate.
1c) Run an awareness raising campaign with older people and the agencies that support them around the nutritional needs of older people and how to spot malnutrition. Communications channels should include non-internet methods as well as web based info	Will be linked to the above. Will make info available as a PDF / web resource to partners as well as in printed format

1d) Ensure that digital inclusion training includes a focus on how to do online food shopping (for example how to set up favourites shopping lists)	No progress yet – need to identify who delivers training currently and take this suggestion to them
1e) BHFP to promote healthy weight programmes in ways that encourage older people to participate and to consider running a specialist Shape Up group for people over 65 yrs old so the dietary advice and activity can be tailored to meet their needs.	Idea of specialist group will be fed into programme planning for 2017. Ongoing monitoring of participation by people 65+ will take place via contract monitoring processes between BHFP and Public Health
1f) Increase the options for people to learn skills and confidence to cook for themselves whether this is cooking from scratch for people who don't know how to cook (e.g.cookery classes for older men) or learning about how to adapt existing skills and use different equipment in response to reduced mobility or sensory impairment.	No progress yet – need to identify resources
1g) Respite offers for carers to include food related activities	No progress yet – need to identify resources
Recommendation 2: Training and support structures	**Progress August 2016**
2a) Establish a unified set of training outcomes on nutrition and dehydration across health, community and social care settings. Roll out training to primary care, hospital teams, frontline staff and volunteers from across the system	No progress to date – BHFP, Public Health and CCG to meet to agree way forward
2b) Improve knowledge amongst professionals about appropriate nutritional information for older people, how to signpost to community based shared meal options, how to spot the signs of malnutrition and appropriate referral	Once booklet has been produced circulate to professionals as well as older people

pathways.	
2c) Provide/continue training on nutrition and cooking skills for family carers and staff in health and social care settings • In particular ensure that Practice Nurses receive training to identify people who may be at risk of malnutrition and how to refer to support and that employees of care agencies who are increasing responsible for putting food on the table are trained in preparing food for older people. This should cover an understanding of nutrition but also should ideally cover basic cooking skills for simple home cooking and given the limited time available could include top tips for microwave cooking.	BHFP putting on a one day training course for support staff on older people and nutrition in October as BHCC has not commissioned this course this year. Will review if this is an effective way to offer training
2d) Use (unpaid) carers network to share information about older people and nutrition including details about shared meals	When booklet is produced use the Carers Centre to circulate
2e) CCG to review use of the MUST tool in care homes settings, including review of the training and support needs of care home staff. MUST tool to be used pro-actively in primary care (ie not just when people are ill) and where malnutrition identified referral to the Dietetics team made. Consider opportunities to provide advice / information about malnutrition in community settings alongside the advice offered by the hospital.	No progress to date – to be discussed as part of meeting re 2a
2f) Extend the number of residential settings with the Healthy Choice Award (or other standard of appropriate / nutritious food provision). Explore the potential for rolling out targeted health promotion work, including around the food agenda with care homes across the city	Promotion to 110 care homes in the city started in July 2016 with mailing (covering both HCA and training available). Follow up calls started in August 2016. Progress report will be made to Public Health in Jan 2017 as funding for this work is via BHFPs contract to deliver healthy weight work in the city

2g) Explore if there is potential to work with supermarkets on 'what makes an age friendly shopping experience	No progress to date
Recommendation 3: Meal provision as part of a care package	**Progress August 2016**
3a) High quality nutritious food provision at home should be available for people who are housebound or who don't want to go out even if they are offered support to do so. The Council's Preferred Providers for Community Meals list should include only nutritious options and delivery services that include a safe and well check	Current providers offer self and well check
3b) Adult Social Care commissioning should have clear arrangements for ensuring accountability in terms of quality of food provision as part of care packages.	To be explored
3c) If food at home is offered via a care package rather than via community meals, then there should be adequate training for carers, and sufficient time allowed for each visit.	As above
3d) There is an opportunity for the city via market development around alternative 'meals on wheels' models (perhaps using the city east/west/central 'hub' division) which could offer greater choice e.g. existing or new voluntary or community groups or social enterprises; other potential providers such as Sussex Partnership NHS Trust, or private companies. There should be an exploration of whether existing kitchens could be used for meal preparation e.g. in day centres, community buildings, school kitchens	There was some interest when there was a tender to be included on the preferred providers list however the timeframe was not long enough to allow for community providers to bid. There may be more interest in a future round
3g) New opportunities to join the preferred providers list for community meals should be promoted to community based organisations	Dates tbc

Recommendation 4: Food outside of the home	Progress August 2016
4a)Link should be made with Brighton & Hove City Council's Healthier Catering Project to explore how work with fast food take aways / neighbourhood cafes can take into account the food and nutrition needs of older people.	No progress to date
4b) Improve the availability and support for voluntary and community sector / neighbourhood level food activity – including gardening projects and shared meal projects. • Future planning on support for food groups such as 'shared meals' providers (e.g. micro- finance, management, help finding volunteers) should take into account the support needs identified by current groups outlined in the Food Partnership's 'Eating Together' report and help these groups to continue to thrive in the face of increasing demand. The Food Partnership and others should develop a project proposal on how best to support this section of the community food sector including support with volunteer recruitment, access to low cost premises and sourcing of affordable healthy food. • Settings providing food in a shared meal setting should ensure they offer a diverse range of options to widen participation eg vegetarian food • Provide information, recipes and training for volunteers / staff running shared meals projects to help them offer a diverse choice and promote their projects widely. • Explore the potential for addressing the gap in provision of shared meals and fresh food provision in the north and east of the city	BHFP secured some funding via the Mental Health Innovation Fund to develop support for volunteer led shared meal providers which covers some of these points – funding report due January 2017
4c) Providers and funders should consider opportunities for providing shared meals / community food activity in new settings within existing resources - for example the new focus for seniors housing as community hubs could provide a setting for residents and/or others in the community.	Hen power established in Rose Hill Court Sheltered Housing BHCC Seniors Housing offering support for Casserole Club and shared meals Some early conversations have taken place with the school

	meals service about opening up the school lunch to older people in the neighbourhood
4d) A lot of shared meal activity is informal e.g. between neighbours. There should be support for initiatives such as 'Know My Neighbour Week'. Further work to understand the potential to operate a 'Casserole Club' scheme (to facilitate neighbours sharing extra portions of food with vulnerable people) should be explored (BHFP and Impetus). If funded pilot is successful partners to investigate ongoing funding for programme	KNMW took place including promotion of food sharing. See later for progress on Casserole Club
4e) Food growing whether at home, via community growing projects or allotment growing has well evidenced positive impacts on health and wellbeing as well as food access, and should be encouraged and supported. Opportunities to volunteer on community food projects should be promoted to older people A concession for allotments for people of retirement age should be retained and easy access plot provided	BHFP Harvest Project promotes opportunities to get involved in food growing projects including for older people. A dementia gardening project has been established. Concession for retirement age plot holders part of proposals being negotiated by Allotment Federation and BHCC
4f) Could/should there be a city wide campaign on the rights of older people to order smaller/ cheaper portions (where they are on offer) in restaurants and/or clarify whether people have the right to order children's portions if they are on offer?	No progress to date

Recommendation 5: Food Poverty	Progress August 2016
5a) Recommendations from this report should be fed into the Food Poverty Action Plan that is being developed for the city noting that in relation to older people food poverty is strongly related to food access	Achieved. The Food Poverty Action Plan has been adopted by the city council and has an annual process for monitoring progress. Organisations represented on the Healthy Ageing Steering Group to be engaged in delivery of FPAP
5b) Providers of furnished housing for older people, whether local authority (e.g. sheltered housing), housing association or private, should be encouraged to offer fridge freezers rather than a fridge with a small icebox, to help with food storage and freezing portions (especially useful for single people) and if appropriate to consider offering specially adapted appliances.	Recommendation passed to Housing team
5c) More discussion should take place with partners to establish if there is a need for a food shopping service	No progress to date. Food Matters have done a bit of research into the 'poverty premium' associated with using local shops. Could be that a shopping service works best in food deserts.
Recommendation 6 – food and social isolation	**Progress August 2016**
6a) Entrenched isolation is especially hard to identify and tackle. Befriending organisations and GP based community navigators play an effective role for helping some of the 'hardest to reach' so should be supported, along with neighbourhood initiatives that promote shared meals to people who are at risk of only eating alone. Increase awareness of shared meal options for those supporting isolated people	Shared meal options will be promoted via the Autumn 2016 Citywide Connect meetings

6b)Pilot Casserole Club for the city to assess the level of interest	Funding for a pilot of Casserole Club was secured by BHFP / Impetus and Brightdials for June – Sept 2016. As of August there were 155 cooks and 40 diners signed up. Ongoing funding required to deliver this work in the city and the partners are working on a longer term funding strategy
6c)With reference to hospital discharge a further meeting should be held with those involved in hospital discharge work at the moment (see notes from steering group meeting) in order to identify where food work and hospital discharge work could be better joined up.	Meeting date agreed for 17th October 2016
Recommendation 7	**Progress August 2017**
Work from this study should be used to inform the city's Dementia Action Plan to ensure that the messages around food, nutrition and dementia are integrated in the overall strategy for dementia.	Information from this report was shared with the CCG Commissioner responsible for work on dementia. The new Dementia Activities Commission included 3 year funding for a project on food growing and cookery for people with dementia and their carers

Appendix 1: Age Friendly City meeting participants

Annie	Alexander	Public Health Programme Manager	Brighton & Hove City Council
Steve	Andrews	Community Participation Worker	The Trust For Developing Communities
Simon	Anjoyeb	Equality Project Manager	BSUH
Vic	Borril		Brighton & Hove Food Partnership
Claire	Corbin		Impact Initiatives
Jules	Dienes	Director	Somerset Day Centre
Linda	Hastings		Impact Initiatives
Ellie	Katsourides	Public Health Team	Brighton & Hove City Council
Tory	Lawrence	Public Health Improvement Specialist	Brighton & Hove City Council
Tracey	Mailtland	Citywide Connect Programme Facilitator	The Fed
Penny	Morley		Older People's Council
Emily	O'Brien		Brighton & Hove Food Partnership
Jo	Lewin		Brighton & Hove Food Partnership
Jess	Crocker		Brighton & Hove Food Partnership
Caroline	Ridley		Impact Initiatives
Lynne	Shields		Age Friendly City Forum
Jess	Sumner	Chief Executive	Age UK
Lizzie	Ward		University of Brighton
Becky	Woodiwiss	Public Health Programme Specialist	Brighton & Hove City Council
Jo	Martindale	CEO	The Hangleton & Knoll Project
Harriet	Knights	Health Catering Project Officer	Brighton & Hove City Council
Keith	Beadle		The Fed
Natasha	Lee	Support Worker	Hanover Housing