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Malnutrition in the Community

Background

On 15th February 2012 the Committee for Health, Social Services and Public Services received an introductory briefing from the Research and Information Service (RaISe) on the subject of Community Meals. Following that presentation the Committee requested further information on the subject of malnutrition, particularly the numbers being admitted to hospital malnourished. There was also interest in any links between such malnutrition and the numbers who were or were not in receipt of 'meals on wheels'. With regard to 'meals on wheels' there was interest in where the meals were produced across the UK, for example, use being made of existing kitchens such as school kitchens and that particular issue is covered in Appendix 1.

The focus of this briefing note is to provide information, as far as possible, on the specific areas of Committee interest and some additional background to the issue of malnutrition originating in the community and the likely impacts on hospital admissions.

Introduction to Community Malnutrition and its Costs

A previous RaISe paper published in November 2009, entitled *Patient Nutrition* (which can be accessed at <http://archive.niassembly.gov.uk/researchandlibrary/2009/10809.pdf>) provided substantial background detail on malnutrition in general and the factors contributing to

it and the Committee may find it useful to reconsider that paper as part of the wider issues surrounding its present interest in providing nutrition to vulnerable people in the community. The Patient Nutrition paper focused primarily on the potential for exacerbation of malnutrition in the hospital setting and the various policies and practices that were being put in place to deal with the issue once a patient was recognised as being malnourished.

Taken from that paper, it is also relevant to this briefing to highlight that malnutrition is defined as the result of dietary intake of an individual that does not meet his or her nutritional needs and in terms of an older and vulnerable population this is often also referred to as undernutrition. In an individual living in the community it usually has a slow onset resulting from weeks to months when the dietary intake has not matched the individual's requirements. The factors that can decrease dietary intake below needs include those that apply to individuals living in the community and those that apply to patients in hospital. The list of such factors includes:²²

- Difficulties with access to or affordability of shopping;
- Difficulties with food preparation, cooking or eating;
- Reduced appetite due to physical or mental illness, disease or its treatment;
- Lack of interest in food due to life circumstance;
- Inadequate or unappetising meals;
- Repeated fasting for diagnostic tests or certain treatments;
- Difficulties with eating, chewing or swallowing; and
- Difficulty with self-feeding.

It is thought that malnutrition is frequently under-recognised in the community setting although it is known to have many negative consequences that affect both the individual and the health service, for example, delayed recovery from illness, poorer treatment outcomes, increased need for healthcare provision in the home, more frequent visits to GPs, more hospital admissions and longer stays.¹

In the UK, a King's Fund Report was among the first to recommend that a simple assessment of nutritional status should form part of the standard assessment process for all hospital patients. More recently the National Institute for Health and Clinical Excellence (NICE) guideline (2006) on nutritional care of adults in hospital recommended that all patients should be screened for malnutrition on admission and all outpatients at their first clinic appointment, with nutrition support considered where appropriate.²

The most frequently used nutrition screening tool in the UK is the **Malnutrition Universal Screening Tool (MUST)** which was devised by the Malnutrition Advisory

¹ Kennelly, S. et. al. (2010), An evaluation of a community dietetics intervention on the management of malnutrition for healthcare professionals, *Journal of Human Nutrition and Dietetics*, **23**, 567-574

² O'Regan, P. (2009) Nutrition for patients in hospital, *Nursing Standard*, **23**, 35-41

Group, a Standing Committee of the **British Association of Parental and Enteral Nutrition (BAPEN)** in 2004 (and amended in 2008). The 'MUST' guide (full details of which are available on the BAPEN website³) includes five steps and management guidelines which can be used to develop a care plan. It is designed for use in hospitals, community and other care settings and can be used by all care workers. The five steps are as follows:

1. Health and weight are measured to get a BMI score using the chart provided (if it is impossible to obtain height and weight an alternative procedure is given);
2. The percentage unplanned weight loss is noted and scored using tables provided in the guide;
3. Any acute disease effect is established and scored;
4. The scores from steps 1, 2 and 3 are added together to obtain the overall risk of malnutrition; and
5. The management guidelines and/or local policy are used to develop a care plan for the patient based on the level of risk.

It is known that malnutrition is a significant burden to the healthcare sector, however, it appears that "*there is no financial information available specifically for the community setting*".⁴ The Advisory Group on Malnutrition, led by BAPEN (British Association of Parenteral and Enteral Nutrition) have estimated the total figure for all public expenditure on disease-related malnutrition in the UK in 2007 at in excess of £13 billion per annum.⁵

Expenditure on oral nutritional supplements (ONS), used to treat malnutrition, has been growing steadily over the past number of years both in the UK and Republic of Ireland. They were estimated to cost the Irish Health Service Executive €28 million in 2008 and in a recent study of ONS prescribing practices in a community setting in the Republic of Ireland, around one third of patients were unnecessarily prescribed ONS. As a result of that study a further study concerning a pilot community dietetics service was developed and is referred to later in this briefing in more detail.⁶ The previous RaISe paper on Community Meals (NIAR 923-11) highlighted the costly use of oral nutritional supplements in Northern Ireland (around £19.2 million annually).⁷

³ BAPEN website 'MUST' tool - www.bapen.org.uk/must_tool.html

⁴ Jones, J. et. al, Older People Living in the Community – Nutritional Needs, Barriers and Interventions: a literature review, The Scottish Government Social Research, 2009, paragraph 4.5

⁵ Combating malnutrition: Recommendations for Action (2008), Report from the Advisory Group on Malnutrition, Led by BAPEN, Edited by M. Elia and C.A. Russell, Key Findings, www.bapen.org.uk/pdfs/reports/advisory_group_report.pdf

⁶ Kennelly, S. et. al. (2010), An evaluation of a community dietetics intervention on the management of malnutrition for healthcare professionals, *Journal of Human Nutrition and Dietetics*, **23**, 567-574

⁷ The importance of nutrition in older people at home, Professor Passmore, QUB, Personal Communication, 7th February, 2012

Malnutrition in the UK and Republic of Ireland – Where Does it Begin?

Research for figures on the prevalence of malnutrition/undernutrition in the older community dwelling population has revealed that there does not appear to be such data readily available and this has been confirmed in one publication specifically for the older community dwelling Scottish population.⁸ The closest estimation of malnutrition originating in the community appears to come from published studies monitoring the number of adults admitted to hospital or care homes who are malnourished.

Large scale surveys on the prevalence of such malnutrition had not been undertaken across the UK until 2007, when the first Nutrition Screening Week (NSW) was held by British Association of Parental and Enteral Nutrition (BAPEN). The purpose of the NSWs is to establish and compare the prevalence of malnutrition in adults on admission to hospitals, care homes and mental health units across the UK using criteria based on the Malnutrition Universal Screening Tool (MUST).⁹

In 2007, Help the Aged (now Age UK) advocated the NSWs, as the charity stated,

*Even though we know malnutrition in older people is a huge problem in the community, the evidence is out of date and patchy. This screening week is therefore extremely important. Until we know the extent of the problem, hospitals and care homes won't have the evidence they need to care for malnourished older patients that are admitted.*¹⁰

All of the four planned BAPEN NSWs have now taken place in 2007, 2008, 2010 and 2011 across the UK with each one carried out in a different season of the year. The Republic of Ireland joined the 2010 and 2011 surveys and the results of the 2011 survey are due to be published in the next month or so. Unfortunately, Northern Ireland did not take part in the 2011 survey.¹¹ The final report based on all four surveys is due to be published in November 2012.

Among the key findings from the 2010 NSW survey (winter 2010) are¹²:

- 'Malnutrition' (classified as medium and high risk of malnutrition according to the Malnutrition Universal Screening Tool ('MUST')) was found to affect more than 1 in 3 adults on admission to hospitals, more than 1 in 3 adults admitted to care homes in the previous six months and 1 in 5 adults on admission to Mental Health Units in the UK;

⁸ Jones, J. et. al, Older People Living in the Community – Nutritional Needs, Barriers and Interventions: a literature review, The Scottish Government Social Research, 2009, paragraph 4.5

⁹ Russell, C.A. and Elia, M. (2010) Conference on 'Malnutrition matters', Symposium 2: The skeleton in the closet: malnutrition in the community. Malnutrition in the UK: where does it begin?, *Proceedings of the Nutrition Society*, **69**, 465-469

¹⁰ Survey to tackle UK malnutrition, BBC News, 24th September, 2007, <http://news.bbc.co.uk/1/hi/health/7010170.stm>

¹¹ Personal email communication with Christine Russell - Project Lead Nutrition Screening Week, BAPEN, 28th February 2012

¹² 2010 Report - Nutrition Screening Survey in the UK and Republic of Ireland in 2010, BAPEN, page 1, Key Points <http://www.bapen.org.uk/pdfs/nsw/nsw10/nsw10-report.pdf>

- Most of those affected were in the 'high risk' category;
- 'Malnutrition' was common in all types of care homes and hospitals, all types of wards and diagnostic categories, and in all ages of adults;
- Much of the 'malnutrition' present on admission to institutions originates in the community; and
- The overall results are similar to those obtained in the summer (2008) and autumn (2007) NSW surveys, with the exception of:
 - A higher prevalence of 'malnutrition' on admission to hospital found in the 2010 survey; and
 - A higher prevalence of 'malnutrition' found on recent admission to care homes in the 2008 survey;

Focusing on the BAPEN results for admission to hospital only the Tables 1, 2 and 3 overleaf, taken from figures in the BAPEN reports, show the **prevalence of 'malnutrition' (medium and high risk according to 'MUST')** in adults across the UK and Republic of Ireland, over the years of the BAPEN NSWs - according to country, type of admission, and source of admission¹³.

NB: For the purposes of this briefing paper there are limitations to the BAPEN studies, particularly in terms of looking at the results for Northern Ireland, as the majority of patients included in the study were from England, with only between 4% and 7% of the patients included in the studies from hospitals in Northern Ireland (these figures are highlighted in the notes beneath the tables). Also it is not known if the hospitals taking part each year in the study from Northern Ireland were the same. Therefore, these figures should be taken as a *potential indication* of the extent of the problem of 'malnutrition' originating in the community in Northern Ireland.

¹³ 2010 Report - Nutrition Screening Survey in the UK and Republic of Ireland in 2010, BAPEN, <http://www.bapen.org.uk/pdfs/nsw/nsw10/nsw10-report.pdf>

2008 Report, Nutrition Screening Survey in the UK in 2008, http://www.bapen.org.uk/pdfs/nsw/nsw_report2008-09.pdf

2007 Report, Nutrition Screening Survey in the UK in 2007, http://www.bapen.org.uk/pdfs/nsw/nsw07_report.pdf

Table 1: 'Malnutrition' according to country

Country	2010	2008	2007
England	35%	28%	29%
Scotland	27%	29%	23%
Wales	33%	40%	26%
Northern Ireland	38%	15%	25%
Republic of Ireland	32%	---	---

NB:

2010 – Total base for UK N=9669, patients were from England 75%, Scotland 12%, Wales 6% and **NI 7%**; Republic of Ireland base N=1602.

2008 – Total base for UK N= 5000, patients were from England 81%, Scotland 9%, Wales 6% and **NI 4%**.

2007 – Total base for UK N= 9336, patients were from England 76%, Scotland 7%, Wales 10% and **NI 7%**.

Table 2: 'Malnutrition' according to type of admission

Type of Admission	2010	2008	2007
Emergency (UK)	39%	34%	32%
Elective (UK)	24%	19%	20%
Not Known (UK)	34%	---	---
Emergency (RoI)	39%	---	---
Elective (RoI)	20%	---	---
Not Known (RoI)	23%	---	---

NB:

2010 – Total base for UK N=9669, in UK 67% of admissions were emergency, 30% elective and 3% unknown.

Republic of Ireland base N=1602, 67% were emergency, 31% elective and 1% unknown.

2008 – Total base for UK N= 5005, in UK 63% of admissions were emergency, 37% elective.

2007 – Total base for UK N= 9137, in UK 67% of admissions were emergency, 33% elective.

Table 3: ‘Malnutrition’ according to source of admission

<i>Admitted from:</i>	2010	2008	2007
<i>Home (UK)</i>	31%	26%	26%
<i>Other Hospital (UK)</i>	41%	34%	31%
<i>Other Ward (UK)</i>	38%	32%	32%
<i>Care Home (UK)</i>	59%	52%	43%
<i>Home (RoI)</i>	30%	---	---
<i>Other Hospital (RoI)</i>	38%	---	---
<i>Other Ward (RoI)</i>	54%	---	---
<i>Care Home (RoI)</i>	54%	---	---

NB:

2010 – Total base for UK N=9669, in UK 71% came from own home, 8% from another hospital, 17% from another ward and 4% from care homes.

Republic of Ireland base N=1602, 86% came from their own homes, 7% from another hospital, 3% from another ward and 4% from care homes.

2008 – Total base for UK N= 5066, in UK 78% came from own home, 6% from another hospital, 13% from another ward and 3% from care homes.

2007 – Total base for UK N= 9298, in UK 76% came from own home, 7% from another hospital, 13% from another ward and 3% from care homes.

BAPEN believe that the data show that much of the ‘malnutrition’ that exists in hospitals originates in the community and that by undertaking nutritional screening in the community, individuals at risk of malnutrition could be identified and treated prior to hospital admission.¹⁴ In some cases, such nutritional intervention may help avoid admissions and re-admissions.

While hospitals provide a good opportunity to identify individuals with, and at risk of, malnutrition it has been proposed by researchers in the field that “*attention should also be given to the identification and management of the problem in the community where it often starts and returns*”.¹⁵

In addition to the BAPEN data, RaISe also sought information from the Department on the number of admissions to hospitals in Northern Ireland where malnutrition was identified, and if possible any information on whether these individuals had been in receipt of the ‘meals on wheels’ service. The information received is detailed in Table 4 below.¹⁶

It is not possible to directly compare the data from the DHSSPS to the ‘snap-shot’ data obtained above by BAPEN during its Nutrition Screening Weeks. However, given the number of inpatient admissions per year in Northern Ireland (around 290,000 in 2010/11¹⁷) what is clear is that the DHSSPS data would indicate a much smaller scale issue than that indicated by the BAPEN data. Further research would be needed to determine what lies behind the differences.

¹⁴ Russell, C.A. and Elia, M. (2010) Conference on ‘Malnutrition matters’, Symposium 2: The skeleton in the closet: malnutrition in the community. Malnutrition in the UK: where does it begin?, *Proceedings of the Nutrition Society*, **69**, 465-469

¹⁵ Russell, C.A. and Elia, M. (2010) Conference on ‘Malnutrition matters’, Symposium 2: The skeleton in the closet: malnutrition in the community. Malnutrition in the UK: where does it begin?, *Proceedings of the Nutrition Society*, **69**, 465-469

¹⁶ Email Response provided by DHSSPS via DALO, 2nd March 2012

¹⁷ Ni Hospital Statistics: Inpatient and Day Case Activity 2010/11, http://www.dhsspsni.gov.uk/inpatient_activity_2010-11.xls

Table 4: Number of admissions and individuals admitted to hospitals in NI (during each of the last five years) where malnutrition was identified as a primary or secondary diagnosis

Year	Admissions	Individuals
2006/07	79	73
2007/08	42	42
2008/09	52	50
2009/10	62	58
2010/11	56	51

Source: Hospital Inpatient System

NB: The DHSSPS advised that in the majority of the above admissions, malnutrition was recorded as a *secondary diagnosis* and was therefore not the main reason for admission to hospital.

Due to the process of identifying and estimating individuals it is possible that an individual who changed address during the time period may be counted more than once.

Information is not available on the number of patients admitted to hospital with a diagnosis of malnutrition who were in receipt of meals on wheels prior to their admission.

Examples of the Potential for Management of Malnutrition in the Community

By way of introduction to the potential for managing malnutrition in the community, this section describes evidence gathering by the Scottish Government on the nutritional needs of older people living in the community, the barriers to them meeting these needs and examples of community interventions; a community dietetics intervention in the Republic of Ireland; and a UK Patients Association survey on malnutrition.

The 2009 Scottish Government publication, *Older People Living in the Community – Nutritional Needs, Barriers and Interventions: a Literature Review*¹⁸ summarised the barriers that may prevent older people meeting their nutritional requirements and these are included in Table 5 overleaf¹⁹.

¹⁸ <http://www.scotland.gov.uk/Publications/2009/12/07102032/0>

¹⁹ Older People Living in the Community – Nutritional Needs, Barriers and Interventions: a Literature Review, The Scottish Government, December 2009, <http://www.scotland.gov.uk/Publications/2009/12/07102032/0>, page 18

Table 5: Factors influencing dietary intake

Poverty and economic uncertainty	<p>Poverty can affect food choice and dietary diversity.</p> <p>Foods integral to a healthy diet (e.g. fruit, vegetables and fish) may be perceived as a luxury.</p> <p>Healthier alternatives to everyday foods can carry a price premium (e.g. wholemeal bread, spreads low in saturates).</p> <p>Food preparation facilities and skills may be limited in poorer households.</p>
Mobility	<p>Immobility may lead to difficulties with shopping, preparing, cooking and eating foods.</p>
Mental health and well - being	<p>Depression can lead to loss of interest in food and Dementia can impact on appetite and food intake.</p>
Social support	<p>Social isolation or emotional trauma can result in disinterest in food, whereas social interaction may encourage eating.</p>
Other health problems	<p>Illness and medications can result in reduced appetite and difficulties with shopping, preparing and eating food.</p> <p>Malabsorption conditions (i.e. gastritis & pernicious anaemia) reduce ability to absorb B₁₂ from food.</p> <p>Problems with incontinence may stop individuals eating and drinking normally and some medication can contribute to constipation.</p>

The Literature Review highlighted that the British Dietetic Association recommends improving nutritional intake via ordinary foods as the first step in the process of providing nutritional support in the community. However, the Review found very few studies investigating the impact of this approach. Some of the key findings in the Literature Review regarding the evidence for current interventions to improve the nutritional status of older people living in the community were²⁰:

- There is evidence to support the use of oral nutritional supplements in hospital settings, but there is limited evidence for the benefit of these in the community setting;
- Dietary advice together with supplements seems to be effective in managing undernutrition;

²⁰ Older People Living in the Community – Nutritional Needs, Barriers and Interventions: a Literature Review, The Scottish Government, December 2009, <http://www.scotland.gov.uk/Publications/2009/12/07102032/0>, page 35

- Weight gain alone should not be considered the primary outcome in research in the area of nutritional interventions. The ability to perform activities of daily living should also be considered;
- There is clear evidence to support vitamin D supplementation but there is concern that this recommendation is being overlooked by both health professionals and the general public; and
- A package of care including diet and activity may be more effective in improving the ability to perform normal day to day activities than diet alone.

In terms of community interventions in Scotland, the Literature Review found many activities ongoing which aim to support the nutritional needs of older people in the community and a database of the projects has been established by Community Food and Health (Scotland). This group and some of the initiatives were referred to in the previous RaISe paper on Community Meals. However, the Review highlighted that it is unlikely that they have been developed as part of research studies so few will have measured outcomes to contribute to the evidence base and it was recognised that a more co-ordinated approach is needed.

A key conclusion of the Literature Review was that

Enhancing nutritional intake and nutritional status should not be considered in isolation but should be considered alongside optimising people's ability to perform activities of daily living, preventing falls and independent living initiatives.²¹

A study was carried out in 2006 and 2007 in one county in the midlands of the Republic of Ireland to evaluate if an education programme supported by a community dietetics service for patients 'at risk' of malnutrition improved the management of malnourished patients in the community²².

An education programme, incorporating 'MUST' training, was implemented for healthcare staff in eight of 10 eligible primary care practices, in seven private nursing homes and two health centres in conjunction with a community dietetics service for patients at risk of malnutrition. Nutritional knowledge was assessed before, immediately after, and 6 months after the intervention using self-administered questionnaires. Reported changes in practice and the acceptability of the education programme were considered using self-administered questionnaires 6 months after the intervention.

²¹ Older People Living in the Community – Nutritional Needs, Barriers and Interventions: a Literature Review, The Scottish Government, December 2009, <http://www.scotland.gov.uk/Publications/2009/12/07102032/0>, page 46

²² Kennelly, S. et. al. (2010), An evaluation of a community dietetics intervention on the management of malnutrition for healthcare professionals, *Journal of Human Nutrition and Dietetics*, **23**, 567-574

The results showed that there was a significant increase in nutritional knowledge 6 months after the intervention. The management of malnutrition was also reported to be improved, with 69% (38/55) of healthcare professionals reporting to weigh patients 'more frequently', whereas 80% (43/54) reported giving dietary advice to prevent or treat malnutrition. Eighty-percent (44/55) of healthcare professionals stated that 'MUST' was an acceptable nutrition screening tool.

Although there were limitations to the study, for example the sample of GP practices was small (eight), the authors believe that it demonstrates that the management of malnutrition in the community is achievable when healthcare professionals receive a specially designed education programme and access to dietetics services.

In August 2011, the UK Patients Association, in conjunction with YouGov, published the results of an online UK wide survey of around 5,000 adults about awareness, knowledge and experiences of malnutrition.²³ The survey focused on boosting responses from those who had been hospital inpatients in the last 12 months; those with a close relative or friend living in a residential or nursing home; and those who are Carers to family or friends. The results of the survey prompted the Patients Association to produce a leaflet '*Malnutrition – signs and symptoms, where to go for help and what to expect from treatment*'. Among many findings, the Patients Association were particularly concerned that 1 in 5 of the general public did not know of any of the treatments for malnutrition that can be used in the community setting, including dietary advice and oral nutritional supplements (ONS). ONS were only known by 31% of the population and by only 38% of the Carers.²⁴

Based on the results, the Patients Association called for a range of actions including:

- Ring-fenced funding for community-based dietetics services and treatment options;
- GPs to be educated on the cost benefits of treating malnutrition in the community;
- The Patients Association leaflet to be provided to patients by GP surgeries and healthcare professionals;
- The Department of Health to:
 - provide information on basic nutrition and the importance of monitoring weight loss as an early warning sign of malnutrition to patients and healthcare professionals; and
 - make nutritional screening across all health and social care sectors mandatory.

²³ Malnutrition in the community and hospital setting, The Patients Association (in association with YouGov), August 2011

²⁴ Malnutrition in the community and hospital setting, The Patients Association (in association with YouGov), August 2011, page

Appendix 1 Production of the Meals for 'Meals on Wheels' – Examples of Service Provision

With regard to 'meals on wheels' the Committee for HSSPS queried whether examples exist across the UK whereby use is being made of existing kitchens, for example school kitchens, to produce 'meals on wheels'. Several lines of inquiry have been followed to seek to provide information in this regard. The evidence would indicate that many of the meals delivered in Great Britain, whether delivered hot, chilled or frozen are produced by one of a few private companies before being heated and delivered by other private care companies or by the Women's Royal Volunteer Service (WRVS) on behalf of a Local Authority.

WRVS

As was mentioned in the previous RalSe paper on Community Meals, across Great Britain the WRVS provide more than four million meals annually across England, Scotland and Wales. RalSe contacted the Head of Food Services in the WRVS in order to ascertain what types of kitchens prepare the meals that the WRVS then deliver and the following information was obtained²⁵:

The services that the WRVS provides falls into three areas:

- **Delivery Only** - These are meals that are delivered by WRVS volunteers on a rota basis anything between 2 or 5 days per week. The meals are usually prepared in Local Authority kitchens (these range from care home kitchens to school kitchens) and are distributed by WRVS staff and volunteers to service users referred by the Local Authority Social Services. Sometimes the meals may be regenerated frozen meals supplied by the Local Authority;
- **Contracted Community Meals** - This where the WRVS have a formal contract with the Local Authority to provide meals on a 365 day basis and where the WRVS regenerate frozen meals and deliver them hot by staff and volunteers across the geographical area of the Local Authority. The clients are usually referred service users from the Local Authority;
- **Private Meals Services** - The WRVS provides a meal delivery to service users on a private basis with no involvement with the Local Authority. This means that WRVS has to go out and get customers by marketing and selling the service on the open market. Often clients have been transferred from a Local Authority Contract service to WRVS on either the ending of the contract period or the Local Authority deciding to remove the subsidy for the meals.

²⁵ Personal email contact with Peter Dicker, Food Services Support Manager, WRVS Food Services, GB Wide Support, 5th March 2012

In the case of the Contracted Community Meals Service and the Private Meals Service the WRVS rents or own property with a regeneration kitchen, whereas in a delivery only service WRVS would only have an office to organise the deliveries from. In several services The WRVS can also provide a sandwich or snack pack delivery along with the delivery of the hot meal at lunch time.

Alongside the meal delivery a safe and well check is provided and with a Local Authority contract the WRVS would pass on any concerns to the Social Services department and in the private service concerns go to the nominated next of kin.

The WRVS acknowledged that although there are very few suppliers that can supply individual complete frozen meals for regeneration, the WRVS insist that all meals it is responsible for heating and delivering comply with the National Association of Care Caterers recommendations for the nutritional content of community meals. The WRVS employ an independent nutritionist to do annual checks on the companies it uses to ensure they are complying with the standards. At unit meal level it monitors the weights both frozen and cooked to see that they comply with the stated weights on the packaging.

The WRVS acknowledged that a freshly cooked meal is preferable to a regenerated pre-prepared meal but it may not be as cost effective. To regenerate a frozen meal a basic oven is all that is required whereas a fresh cooked meal is more labour intensive and the cost of running a full kitchen is considerably more.

Two specific examples are as follows:

- **Vale of Glamorgan (Wales)** – the meals are purchased from the private company *Apetito* and then regenerated and delivered by the WRVS²⁶;
- **East Renfrew (Scotland)** – the meals are produced in a local school kitchen and delivered by the WRVS.²⁷

Selected County Councils

RaISe also contacted two randomly selected County Councils in England to determine where the 'meals on wheels' meals are produced for the Social Services:

- **Staffordshire County Council** advised that a private company called *ICare Group* provide the meals on wheels service for the Council. *ICare* then advised that the meals are produced by several private companies - *Apetito* (Wiltshire Farm Foods), *Sodexo* (Tillery Valley Foods) and *Punjabi Foods* (Asian and Halal meals). The meals are then delivered by *ICare* to the client either frozen or in some cases *ICare* heat the meals in their kitchens before delivery. *ICare* do not produce any meals.

²⁶ Personal communication with Vale of Glamorgan WRVS, 2nd March 2012

²⁷ Personal communication with East Renfrew WRVS, 2nd March 2012

(ICare provide social services for all of NW England, Staffordshire, Leicester, Birmingham, Coventry, Wigan and the Wirral).²⁸

- **Lancashire County Council** advised that a private company called Care Connect UK provides its social care services, however that company does not provide a meals on wheels service, carers will prepare a meal a home if this is part of the care package. Other social care clients of the council are referred on to private meal providers, for example, Wiltshire Farm Foods referred to above and meals are purchased with direct payments.²⁹

Fife Council - Scotland

The previous RaISe paper on Community Meals highlighted the 2011 Scottish publication - *Meals and Messages*, a report focusing on food services for older people living in the community in Scotland. Case study material highlighted *Fife Council Meals on Wheels Service* as an exemplary all week hot meal delivery service. Fife Council has since advised RaISe that at present the meals are bought in from a selection of private companies and then heated in council kitchens before delivery.³⁰

²⁸ Personal communication with ICare, 1st March 2012

²⁹ Personal communication with Lancashire County Council and Care Connect UK, 1st March 2012

³⁰ Personal Communication with Fife Council, 1st March, 2012