Notes from the roundtable discussion on a focus on food services for older people 25 February 2010 hosted by Community Food and Health (Scotland) and Consumer Focus Scotland

Participants

Liz Breckenridge	Consumer Focus Board (Chair)
Neeru Bhatnagar	BME Elders Group
Anthony KK Chu	Trust/ Hanover/Bield Housing Association
Michael Craig	NHS Health Scotland
Sue Gregory	CFHS Steering Group
Michelle McCrindle	The Food Train/CFHS Steering Group
Elinor McKenzie	Scottish Pensioners Forum
Anne Milne	Food Standards Agency
Marcia Ramsay	Care Commission
John Storey	Scottish Government
Sue Rawcliffe	Community Food and Health (Scotland)
Alice Baird	Community Food and Health (Scotland)
Mary Lawton	Consumer Focus Scotland
Anne-Marie Sandison	Consumer Focus Scotland

1. Welcome and introduction

The Chair welcomed the group and gave background to the meeting.

2. Apologies for absence

These had been received from;

Ron Culley	COSLA
Brian McKechnie	Scottish Centre for Intergenerational Practice
Linda Miller	Scottish Government
Lisa Wilson	Carolyn Walker Trust
Yvonne Coull	Centre for the Older Person's Agenda contacted after the meeting to say she had been stuck in the snow.

3. The current picture - older people's access to affordable healthy food of their choice

(1) <u>What are the barriers?</u>

Participants discussed the current picture with regard to older people's access to affordable healthy food of their choice and looked at the barriers in relation to this, the range of current services, and the role of community food initiatives.

Participants noted many barriers to access to affordable healthy food: these were physical barriers such as geography, with variances in availability between urban and rural areas; whether local shops were supermarkets or smaller convenience stores and the difference in cost between the two; issues around availability of transport, with the loss of driving licence seen as a major factor in this; low income (it was raised that some people's food choices could be determined by not being able to afford new teeth); levels of mobility/physical ability and general health; and the nutritional quality of delivered food, which can often be microwave ready meals;

There were also psychosocial barriers noted, such as a lack of cooking skills, particularly for older men living alone; the affect of loss and grieving; social isolation; lack of appetite/interest in food. The social aspect of preparing and eating food together was highlighted as something which had been successful with other groups, such as homeless groups.

Poverty among older people is also a key barrier. An inadequate pension, living on an income of less than £100 per week seriously affects what you can eat. Many older people do not claim pension credits that they are entitled to. A process of gradually decreasing expectations among older people was described, contributing to their not demanding better services. It was felt that health should be seen as a right, not a benefit.

It was important to recognise that solutions for food services for older people werenot necessarily permanent requirements, with people often needing help due to changes of circumstances such as illness, but then able to cope again on their own. This dynamic nature was a barrier in itself.

The point was made that barriers could be seen as tipping points for older people as to when they may need help. Examples were:

- no longer able to drive
- loss of teeth
- loss of local transport services
- bereavement
- mental health problems
- podiatry/ortho/eye problems

These changes should be seen as a prompt to providing information about services available.

(2) Discussion on the range of current services available raised many issues, including:

- lack of commonality in service provision across Scotland
- change in services available to people pre and post 65 –eg. shopping is not part of free personal care after 65.

- lack of provision for ‘short burst illness’ – there needs to be flexibility so people can use services for differing lengths of time
- range of abilities and expectations in over 55 age group
- lack of personalised care service
- differences in delivered food, whether this was meals on wheels; raw ingredients; frozen; fresh; ready meals etc
- variation in standards in care homes, some catering for nutritional needs very well and others not
- the challenge of the balance between task and time in commissioned home care services and the variation in quality of what is available. This variation is also across the public, private and voluntary care sectors.
- no opportunity to cook for yourself in care homes, and issues with health and safety about food being brought in
- suitability of food in hospital settings, particularly for BME patients where families and friends are providing culturally appropriate food.
- The impact of dementia for some older people which results in them both forgetting to eat and how to eat.

It was noted there were also many factors around how people access services and how much ownership they have over the help that is given. Most of the Food Train’s customers self-refer and it was felt that this is important to empower people to make decisions for themselves.

The issue of the availability of information on available services was raised. The Food Train promotes its services by talking to older people’s groups in village and church halls, as well as distributing a quarterly newsletter to health and social care providers, and leaflets to GP practices and council offices. Leaflets are also made available in pubs and betting offices, to target the social habits of older men.

Lunch clubs were seen as key within communities, whether within social work funded day centres or run by volunteers, especially in regard to the social aspect of eating together. Older people are able to access a hot meal and at the same time meet and eat with others. This was seen to be particularly important in BME communities as a place where people sharing a common language and culture can get together and access culturally appropriate food and information

It was noted that some lunch clubs have had to close because they have no food hygiene certificate and that funding difficulties /local authority spending cuts are threatening others.

The question of how Consumer Focus Scotland/Community Food and Health (Scotland) might support lunch clubs was raised, with CFHS in a position to provide information and training and CFS providing a voice on behalf of lunch club users. The possibility of a briefing note to local authorities emphasising their value to older people and the health and wellbeing benefits was discussed.

Meals on Wheels services were discussed. These have been traditionally carried out by WRVS and cooked in schools. However there was the cost of keeping the kitchens open in the holidays so some Local Authorities had moved to providing frozen meals then. Now that schools were being built without kitchens, many were

just providing frozen meals. Others just provided hot meals on alternate days with frozen meals given at the same time for the other days. Very few provided a full week service.

This could be very confusing for older people and also meant less social contact.

Concern was expressed that the full picture regarding food services was not clear. As well as Local Authority provision, there were voluntary initiatives as well.

(3) The role of community food initiatives

The discussion moved on to the role of community food initiatives in the provision of food services to older people. The wide variety of community food and health activity, both run by and for older people, include gardening projects, cooking classes, meals delivery services, community cafés, food delivery services, supported shopping, community transport, food co-ops in sheltered housing complexes and box schemes. What makes them unique is that they are usually developed and run by older people themselves and that they are rooted in people's own communities and often highly valued. Community initiatives can also mobilise local resources – volunteers, fundraising and are potentially more cost-effective. They are also in a good position to reduce isolation and build community support.

4 Areas for improvement

(1) Possible areas for future practice innovation

Discussion then moved on to taking work in this area forward, looking at areas for practice innovation.

It was felt that there was a lack of awareness among older people of what services are available in their area and that information provision is an area that could be built on.

Participants also questioned whether there are any food outlets that are not presently being utilised by older people, such as school meal services and community or supermarket cafés.

The idea of a one-stop shop with integrated services such as health promotion, financial advice and social activities was also discussed, as was the issue of care homes being integrated into the community.

Work is also needed on sharing good practice. The Care Commission has developed nutritional champions across care homes and an ongoing learning network to share good practice. There is a need for similar initiatives in other sectors.

There is a need to build capacity and confidence around culturally appropriate food provision. The International Café model at CORE provides a possibility of developing this as a social enterprise and building skills across organisations.

It is important to appreciate the strength of tried-and-tested models such as lunch clubs and meals on wheels and look at how to support these.

(2) Possible areas for future research

Possible areas for research discussed included:

- mapping existing service provision, particularly commissioned services and identifying gaps and differences
- housing services for older people and how these link with community services
- link between cold weather deaths and nutrition
- nutritional status of older people in Scotland. FSA have a methodology for doing this which costs £1000 per person.

The role of older people writing and carrying out their own research was discussed – the Food Train had been a positive example of this.

The importance of anecdotal evidence of experiences was stressed and it was felt that future research should feature qualitative methods as well as quantitative. Older people's testimony matters and has to be a key part of any future research agenda.

It was also suggested that rather than seeing practice innovation and research as two separate strands, they could be combined into some action research work. This could possibly tie in with CFHS small grants scheme.

(3) Role of stakeholders in taking this forward

The Chair noted that it was important that older people had an 'external voice' at a time when cuts to services were a possibility. She thought that CFS with its particular remit for the vulnerable should consider this. Discussions on a possible work plan item were ongoing at the present time.

Others present found the meeting useful and would be interested in principle in taking forward the points raised.

It was also felt that Consumer Focus may have a role in questioning retailers' higher pricing of small portions of food, which also ties in with food waste and obesity campaigns.

5. Next steps

The Chair thanked everyone for such wide-ranging and constructive input. Notes from the session would l be circulated to all who were invited and both Consumer Focus Scotland and Community Food and Health (Scotland) would feed the issues raised into their work plans.

Once work plans had been agreed, the outcomes and any further work would be discussed with participants.