Letters

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The cost of living crisis: how can we tackle fuel poverty and food insecurity in practice?

Khan rightly identifies food insecurity as a public health concern.[1] Because of the COVID-19 pandemic and the current cost of living crisis, the number of people at risk of food insecurity/hunger is starkly increasing.[2] As the author suggested, healthcare providers should feel best situated to identify sections of our population experiencing the real impact of the cost of living crisis. But should we only stop at highlighting the prevalence of the issue? We need to move to the next step and take action. The focus should be to empower clinicians to implement practical solutions for their at-risk patients.

At a local level, health and social care providers should consider partnering with community initiatives and services that provide the much-needed support for people facing food insecurity. Social welfare programmes concerned with the health of individuals experiencing poverty include:

- No Child Goes Hungry Initiative (Bristol City Funds); and[3]
- Food and Fun in Wales.[4]

Food provided by food banks should address patients' health issues related to poor nutrition. Because poor access to nutritious food translates to adverse health outcomes,[5] the role of social prescribing, for example, council schemes with food vouchers based on the household support fund,[6] should be utilised. Eligible families can be directed or assisted to access the NHS 'Healthy Start' milk and food card scheme (https://www.healthystart.nhs.uk/). In addition, healthcare providers can direct patients to other welfare support services such as Citizens Advice and housing and financial advice services.[7]

Medical professionals played critical roles in changing policy during other health crises, for example, campaigning for the smoking ban and ending tobacco advertising.[8,9] The issue of hunger and food poverty should garner the same campaigning from the medical profession. The ethical obligation of healthcare providers extends beyond asking our patients if they are at risk of food insecurity to encompass local collaboration, policy advocacy, and action.

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REFERENCES

1. Khan N. The cost of living crisis: how can we tackle fuel poverty and food insecurity in practice? *Br J Gen Pract* 2022; DOI: https://doi.org/10.3399/bjgp22X719921.
2. Ferguson H, Kelly L, Pink S. Social work and child protection for a post-pandemic world: the re-making of practice during COVID-19 and its renewal beyond it. *J Soc Work Pract* 2022; **36(1):** 5–24.
3. City Funds. Health & wellbeing. 2022. https://bristolcityfunds.co.uk/areas/health-wellbeing/ (accessed 6 Sep 2022).
4. Welsh Government. £4.85m for food and fun this summer. 2022. https://gov.wales/485m-food-and-fun-summer (accessed 6 Sep 2022).
5. Militao EMA, Salvador EM, Uthman OA, *et al.* Food insecurity and health outcomes other than malnutrition in Southern Africa: a descriptive systematic review. *Int J Environ Res Public Health* 2022; **19(9):** 5082.
6. Department for Work and Pensions. Household Support Fund: guidance for local councils. 2021. https://www.gov.uk/government/publications/household-support-fund-guidance-for-local-councils (accessed 6 Sep 2022).
7. British Medical Association. *Health at a price: reducing the impact of poverty.* London: BMA, 2017. www.bma.org.uk/media/2084/health-at-a-price-2017.pdf (accessed 6 Sep 2022).
8. Jassem J. MS24.03 The importance of physician involvement in tobacco control. *J Thorac Oncol* 2018; **13(10):** S292.
9. Moxham J, Munro A. The BTS and Doctors for Tobacco Law: working towards ending tobacco advertising. *Thorax* 1995; **50(1):** 6–8.

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Antibiotics versus no treatment for asymptomatic bacteriuria in residents of aged care facilities: a systematic review and meta-analysis

Many thanks to the authors for this review.[1] Although it has been clear for a while and is increasingly so, it's an important reminder that older people in residential care can develop non-specific symptoms for many reasons, and a positive urine dip is not nearly conclusive evidence that the cause is the ever-suspected 'UTI'.

Regarding the studies analysed — it is (as the authors acknowledge) difficult to assess the clinical condition of the participants — in practice, it is almost always the case that the patient being discussed has 'something', for example, acute confusion, drowsiness, reduced appetite, and so on, that has led to the urinalysis in the first place. However, on further questioning, UTI-specific symptoms such as suprapubic pain, dysuria, frequency, or urgency are often absent (usually complicated by the patient's background cognitive impairment making communication of symptoms difficult).

Is there any distinction to be made in further research between completely asymptomatic patients, those with non-specific symptoms, and those with symptoms that truly are indicative of UTI?

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REFERENCE

1. Krzyzaniak N, Forbes C, Clark J, *et al.* Antibiotics versus no treatment for asymptomatic bacteriuria in residents of aged care facilities: a systematic review and meta-analysis. *Br J Gen Pract* 2022; DOI: https://doi.org/10.3399/BJGP.2022.0059.

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