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PRESCRIBING ONS: THE REQUIREMENTS FOR INDIVIDUAL CLINICAL CIRCUMSTANCES

NHS England Guidance on Commissioning Excellent Nutrition and Hydration 2015-2018,¹ NICE Clinical Guideline 32 on Nutrition Support in Adults (CG32)² and NICE Quality Standard 24 (QS24),³ support the use of Oral Nutritional Supplements (ONS) whenever there is a clinical need to do so.

The provision of ONS on prescription ensures that under the supervision of a healthcare professional, all patients, including the most vulnerable, are able to access the products that are most appropriate for their care, whenever they are needed.

Which prescriptions are available in any given area depends on the policy of each Clinical Commissioning Group (CCG), the clinically-led statutory bodies responsible for the planning and commissioning of healthcare services for their local area. Facing significant pressure to cut costs, some CCGs are limiting, or restricting, prescriptions of ONS - with health ramifications that are increasingly worrying.

Malnutrition continues to be a serious problem in modern Britain, with more than three million people in the UK estimated to be either malnourished or at risk of malnutrition.⁴ The number of deaths from underlying malnutrition, or where malnutrition was named as a contributory factor, is also increasing, having risen by more than 30% from 2007 to 2016.⁵ This is unacceptable in any modern healthcare system.

To be tackled effectively, malnutrition needs to be screened, identified and managed appropriately. However, it appears that there are fundamental inconsistencies in the implementation of CG32, QS24 and the other recommended strategies. Malnutrition remains a growing problem, yet is largely preventable and can be better managed if the right guidance is followed.

HOW DO ONS SUPPORT GOOD PATIENT OUTCOMES?

ONS are evidence-based nutritional solutions for disease-related malnutrition.⁶ These highly regulated products⁷ can partially, or wholly, replace a normal diet to provide patients with the essential nutrients they need when food alone is insufficient to meet their daily needs.^{2,3,8} QS24 recognises that ONS are a clinically effective way to help manage disease-related malnutrition:

'It is important that nutrition support goes beyond just providing sufficient calories and looks to provide all the relevant nutrients that should be contained in a nutritionally complete diet. A management care plan aims to provide that and identifies condition specific circumstances and associated needs linked to nutrition support requirements.'

Healthcare professionals are best placed to evaluate whether patients need ONS and if so, for how long patients should be taking them. They can also provide patients with the most appropriate products for their individual clinical conditions and circumstances. ONS can play an essential part in medical management, acting as invaluable support when food alone is insufficient, either for short periods of time, or for life. Receiving timely ONS is essential in the prevention and management of malnutrition and patients should only be prescribed ONS

REFERENCES

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when they cannot meet their daily nutritional requirements from food alone, and/or are at risk of malnutrition due to a disease, disorder, medical condition or surgical intervention.

Combined with regular monitoring and review of patients' individual needs and circumstances by a healthcare professional, as outlined in CG32, QS24 and the Managing Adult Malnutrition in the Community Pathway,⁸ ONS provide the most effective management solution for patients who are malnourished, or at risk of malnutrition. ONS should be discontinued when an individual is no longer malnourished, has met their nutritional goal(s) and is able to meet their nutritional needs through food alone.

POWDER OR LIQUID?

ONS are available in two different forms: powders (which are made up to form a liquid), or ready-made liquids. The decision about which form to prescribe is an important one and should be carefully considered. Both have their advantage, but ultimately the decision about which is the best option should come down to the specific clinical circumstances and requirements of the patient; there is no blanket approach. Factors to consider might include the level of the patient's dexterity, mobility and sight and: whether they can tolerate volume; can tolerate milk; are able to make up the product accurately; are able to access milk; are able to swallow safely; and their individual preferences.

ADHERENCE TO NUTRITION MANAGEMENT GUIDELINES

CG32 and QS24 set the standard for appropriate and timely nutritional care and should be followed in all care settings.

The Malnutrition Universal Screening Tool ('MUST')⁹ is a recommended screening tool with five steps, which allows healthcare professionals to identify and manage nutritional issues, including both malnutrition and obesity. It includes the use of BMI calculation, consideration of unplanned weight loss and the effect of acute disease, as well as guidelines that can then be used to help establish a care plan for the individual based on their level of risk.

Unfortunately, even though patients, care home residents and those receiving support in the

community, should - and can easily be - screened and assessed for malnutrition, this is not always the case. Even in the cases where 'MUST' is being used, it can sometimes be viewed as a tick box exercise, meaning that patients do not always receive an appropriate management plan when they should.

The Managing Adult Malnutrition in the Community Pathway⁸ is an evidence-based tool founded on clinical experience and evidence alongside accepted best practice that can be used across all care settings, and which is endorsed by professional organisations such as the British Dietetic Association (BDA), British Association for Parenteral and Enteral Nutrition (BAPEN), Royal College of Nursing (RCN) and Royal College of General Practitioners (RCGP). The document includes a pathway to assist in the appropriate use of ONS. Healthcare professionals managing patients who have had a recent stay in hospital should find it particularly useful.

Revised and updated in December 2017, it has been endorsed by NICE as follows: 'This booklet supports the implementation of recommendations in the NICE guideline on nutrition support for adults (CG32). It also supports statements 1, 2 and 5 in the NICE quality standard for nutrition support in adults (QS24).' For more information on the pathway and updated supporting documents available to download, visit www.malnutritionpathway.co.uk.

UNDER-REPORTING OF MALNUTRITION

The increasing number of cases of malnutrition in hospital and associated deaths reflect a system-wide failure to consistently screen and manage patients who are either malnourished or at risk of malnutrition.⁴ Drawing upon malnutrition data broken down by NHS Trust for 2015/16,¹² new research commissioned by the British Specialist Nutrition Association (BSNA)¹³ explored the current reporting of malnutrition in hospitals in England. Using the latest publicly available data to analyse malnutrition rates across 221 English NHS Trusts, the research identified Trusts where the recording of malnutrition is significantly below expectation. The research found that more than half the hospital Trusts in England are significantly under-reporting malnutrition rates compared to accepted national estimates.



It costs more NOT to treat malnutrition than to do so. It is estimated that £5,000 could be saved per patient through better nutrition management.

This means that the overall incidence of malnutrition is likely to be significantly under recorded, pointing to a much more significant problem than the available data suggests.

NICE Quality Standards are designed to measure and improve quality of care in specific areas. Estimates point to malnutrition as a sustained problem across the country, but the data is incomplete due to the non-mandatory nature of nutrition reporting and management.

Were CG32 and QS24 implemented in full, comprehensive records would exist on the nutritional status of all in-patients, care home residents and people receiving care in the community. However, because adherence to Quality Standards and Clinical Guidelines is not mandatory, this is not the case.

THE COST OF MALNUTRITION

The cost of doing nothing significantly outweighs the cost of early intervention, such as dietetic support and provision of ONS if appropriate.

Malnutrition results in various adverse health outcomes for patients, including high numbers of non-elective admissions, greater dependency on hospital beds for longer and progression to long-term care sooner. Managing patients in a crisis situation results in high levels of inefficiency, which could be avoided or minimised if more focus were placed on prevention and early intervention.

The health and social care costs associated with malnutrition are estimated to be £19.6 billion per year in England alone, amounting

to more than 15% of the total public health expenditure on health and social care.¹⁴ About half of this expenditure is on older people (>65 years). A BAPEN report published in 2015 stated that, 'interventions with nutritional support (to implement the NICE clinical guidelines/quality standard), including ONS, enteral tube feeding (ETF) and parenteral nutrition (PN) in hospital and community settings, were found to lead to greater net cost savings than those reported by NICE. The savings were even greater when the prevalence of malnutrition was high, when hospital admission rates were high, and when the gap between current care and desirable nutritional care was high.'¹⁴ From the BAPEN report, five different models, which involved nutritional support in 85% of subjects with a high malnutrition risk, all resulted in cost savings.

It costs more NOT to treat malnutrition than to do so. It is estimated that £5,000 could be saved per patient through better nutrition management.¹⁴ The provision of nutritional support to 85% of patients at medium and high risk of malnutrition would lead to a cost saving of £325,000 to £432,000 per 100,000 people.¹⁴

On average it costs £7,408 per year to care for a malnourished patient, compared to £2,155 for a well-nourished patient.¹⁴ **Implementing NICE CG32 and QS24 in 85% of patients at medium and high risk of malnutrition would lead to a net saving of £172.2-£229.2 million, which equates to £324,800 to £432,300 per 100,000 people.**¹⁴

NICE has also found that the implementation of CG32 and QS24 into a pathway of nutritional care would produce an overall cost saving, while improving quality of care. Nutritional support in adults was ranked as the third highest amongst a wide range of other cost saving interventions associated with implementation of NICE guidelines/standards.¹⁴

The impact on local areas is considerable, since 93% of malnutrition is estimated to occur in community settings. However, the largest cost comes from the management of malnourished people in hospitals, even though they only account for 2% of cases.⁴ Comprehensive, effective screening, prevention and treatment, and the introduction of incentives, are essential across all settings to protect those at risk of malnutrition and reduce costs to taxpayers.

A study conducted in the USA in 2017¹⁵ has also demonstrated the clinical and economic value of nutritional intervention. The study assessed the potential cost-savings associated with decreased 30-day readmissions and hospital length of stay in malnourished in-patients through a nutrition-focused quality improvement programme. The reduction in readmission rate and length of stay for 1,269 patients enrolled in the quality improvement programme were compared with pre-quality improvement programme baseline and validation cohorts to calculate potential cost savings. The reduction in hospital readmissions and reduced number of days in hospital for patients in the quality improvement programme resulted in cost savings of \$1,902,933 versus the pre-quality improvement programme baseline cohort, and \$4,896,758 versus the pre-quality improvement programme in the validation cohort. After assessment of the entire patient population, per patient net savings of \$1,499 when using the baseline cohort as the comparator and savings per patient of \$3,858 when using the validated cohort as the competitor were achieved. The study showed that nutritional interventions improve health outcomes and reduce the overall costs of care in malnourished hospitalised patients.

MANAGING PATIENTS' NUTRITIONAL NEEDS

Prevention and management of malnutrition require early action to reduce the risk of longer-term complications. Prescribed whenever there is a clinical need to do so, ONS can ensure that patients' nutritional needs are managed adequately and that further complications do not arise. They are an integral part of the

management of long-term conditions that require nutritional support and should be accessible to all patients who need them.

There is little evidence of efficacy of managing disease-related malnutrition with food-based strategies alone compared to the use of ONS.¹⁶ Yet, despite this, against a backdrop of increasing cost pressures on the NHS, some CCGs have started to restrict prescribing of ONS, which requires an initial outlay, but consistently brings savings arising from the prevention of later associated complications. Fortified food has been provided instead in some cases, but this approach is over-simplified and often does not account adequately for patients' individual clinical requirements, or the clinical assessments made by healthcare professionals.¹⁷ Healthcare professionals, commissioners and policymakers across all settings must balance investment in ONS and dietetic services against consideration of unintended consequences and longer-term burdens, to both patients and the NHS, that can be exacerbated without action. The provision of dietary advice and ONS to malnourished patients reduces complications such as infections and wound breakdown by 70% and mortality by 40%.¹⁸

When CCGs are looking to reduce their overall expenditure on prescription costs, it is important to look at the burden of malnutrition in the local health economy, in terms of hospital admissions and readmissions, and to ensure that the nutritional needs of patients are being managed appropriately. Immediate savings from cutting ONS can lead to higher costs due to increased healthcare use in the longer term.

CONCLUSION

The importance of good nutrition should not be understated. Whilst considerable focus has been given to obesity in recent times, malnutrition still remains the poor relation, notwithstanding the size and scale of the problem. Yet, obesity and malnutrition are both states on the nutritional spectrum and the goal of public health intervention should be to ensure good nutritional status for the population as a whole.