

Prescribing ONS

What patients' particular clinical circumstances require



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Introduction

Medical nutrition (medical foods) can support individuals who cannot meet their nutritional requirements through a normal diet and/or help them to manage their condition. Oral nutritional supplements (ONS) are an essential part of a care pathway for those patients who are unable to support themselves through conventional nutrition, as well as being a clinically and cost-effective way to manage malnutrition when prescribed and monitored appropriately. The NHS England Guidance on Commissioning Excellent Nutrition and Hydration 2015-2018,¹ the National Institute for Health and Care Excellence (NICE) Clinical Guideline 32 on Nutrition Support in Adults (CG32)² and NICE Quality Standard 24 (QS24)³ all support the use of ONS wherever there is a clinical need. QS24 states that: *"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."*

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

To be tackled effectively, malnutrition needs to be screened, identified and managed appropriately. However, it appears that there are recurrent 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.

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. ONS are evidence-based, highly regulated nutritional solutions⁶ for disease-related malnutrition.⁷ Which prescriptions are available in any given area depends on the policy of each Clinical Commissioning Group (CCG), the clinically-led statutory bodies that are 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 potential health ramifications that are increasingly worrying.

How do ONS support good patient outcomes?

ONS are an essential part of a care pathway for patients who are unable to support themselves through conventional nutrition, as well as being a clinically and cost-effective way to manage malnutrition when prescribed and monitored appropriately, as outlined in the Managing Adult Malnutrition in the Community Pathway.⁸ This is a tool based 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), Royal College of General Practitioners (RCGP) and NICE. It includes a pathway to assist in appropriate nutritional management, including setting goals, deciding on dose and duration of ONS, how and when to monitor progress and when to discontinue a prescription.

Evidence supports the value of ONS, both in terms of cost and clinical outcomes

- 1 in 4 adults admitted to hospital are malnourished or at risk of malnutrition, increasing to 1 in 3 for those residing in care settings including those

malnourished in the community.⁹ At any point in time more than 3 million people in the UK are estimated to be malnourished or at risk of malnutrition⁴

- Evidence from a number of systematic reviews and studies, including NICE CG32,² and NICE QS24,³ show that ONS are a clinically effective way to manage disease-related malnutrition. QS24 recommends that people who are malnourished, or at risk of malnutrition, have a management care plan that aims to meet their complete nutritional requirements, while CG32 supports healthcare professionals to identify malnourished people, helping them to choose the most appropriate form of support.

- NHS England's Commissioning Excellence in Nutrition and Hydration Guidance⁹ recognises that malnutrition and dehydration have a large impact on the health economy with increased demands on GP services, out-of-hours services and increased rates of transition across pathways of care. Unfortunately, however, all too often these guidelines and standards are forgotten or ignored, even though NHS England's 10 Key Characteristics of 'Good Nutrition and Hydration Care'¹⁰ recommends that "all care providers have a nutrition and hydration policy centred on the needs of users, [which is] performance managed in line with local governance, national standards and regulatory frameworks".
- Evidence shows that management of malnutrition supports not only positive health outcomes, but also reduces costs to the NHS. When malnutrition is identified and managed appropriately there is a potential net saving of £324,800 to £432,300 per 100,000 people.¹¹

ONS are approved by the Advisory Committee on Borderline Substances (ACBS) specifically for certain indications in the management of a variety of medical conditions and disorders, e.g. short bowel syndrome, intractable malabsorption, pre-operative preparation of patients who are undernourished, proven inflammatory bowel disease (IBD), following total gastrectomy, dysphagia, bowel fistulae, etc., to support individuals who cannot meet their nutritional requirements through a normal diet and/or help them manage their condition. ONS are also developed in a range of formats, flavours and compositions (for example, high protein, high fibre, low volume, pre-thickened for dysphagic patients) and are available in liquid and powdered form designed to meet individual patient requirements and to maximise compliance in different patient groups: the type chosen will depend on the specific individual, their condition and circumstances. BSNA has produced a resource which may be helpful, entitled 'Choosing the appropriate oral nutritional supplement'.¹² To cater both for the variety of medical conditions and for patients' needs and preferences, it is important that a range of formats of ONS continues to be available.

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 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.

More than half the hospital trusts in England are significantly under-reporting malnutrition rates

The Malnutrition Universal Screening Tool ('MUST')¹³ is a recommended screening tool with five steps, which allows health and care professionals to identify and manage nutritional issues, including both malnutrition and obesity. It includes the use of a body mass index (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 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. Drawing upon malnutrition data broken down by NHS Trust for 2015/16,¹⁴ research commissioned by the British Specialist Nutrition Association (BSNA)¹⁵ in 2017 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. 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 doing nothing significantly outweighs the cost of early intervention, such as dietetic support and provision of ONS when appropriate

Over half of the costs associated with malnutrition are attributable to the over 65s,¹¹ and this group is set to increase by more than 50% over the next 25 years.¹⁶ Therefore, any guidance which restricts access to those in need of ONS could have severe medium and longer-term consequences, especially considering that this group of patients may be most challenged by the burden of multiple comorbidities, impacting their ability to regularly shop and also being least able to afford to increase their household expenditure. Earlier identification and management of malnutrition is consequently essential,⁸ both in the hospital and in the community, and ONS can provide a vital lifeline to patients who, without their support, would become or remain malnourished.

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.¹¹ 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."¹¹

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.¹¹ On average **it costs £7,408 per year to care for a malnourished patient, compared to £2,155 for a well-nourished patient.**¹¹ 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-£432,300 per 100,000 people.¹¹

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.¹¹

The impact on local areas is considerable, since 93% of malnutrition is estimated to occur in community settings. However, the largest cost derives 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 2017,¹⁷ 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.

There is little evidence of efficacy of managing disease-related malnutrition with food-based strategies alone compared to the use of ONS.¹⁸ Yet despite this, against a backdrop of increasing cost pressures on the NHS, some CCGs have started to restrict prescribing of ONS, which require an initial outlay but consistently bring 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. 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%.⁷

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

Malnutrition is an avoidable cost to the NHS, but remains a pressing concern. Prevention and treatment of malnutrition requires initial outlay, early action and a joined-up approach to reduce the risk and cost of longer-term complications.

BSNA recommends the following actions be taken to promote improved health in the population, and to reduce the burden of disease-related malnutrition on the NHS:

1. The introduction of a new, comprehensive jointly developed and delivered integrated clinical care pathway for the frail elderly, across all systems.
2. CG32, QS24 and the Managing Adult Malnutrition in the Community Pathway should be implemented and followed in all healthcare settings. In particular, since guidelines are not being followed in reality, BSNA calls for CG32 to be made mandatory.
3. Incentives should be considered to transform clinical practice, including how malnutrition is identified, recorded and managed, perhaps by the introduction of a new Quality and Outcomes Framework (QOF) (or equivalent) and/or CQUIN on malnutrition, which could transform how malnutrition is identified, recorded and managed.
4. ONS should be recognised as an integral part of the management of long-term conditions that require nutritional support, alongside food. They should be accessible to all patients who need them, and all care pathways should clearly identify how ONS should be used to help manage patients' conditions. Patients should be regularly monitored by a healthcare professional so that the nutrition intervention is reviewed accordingly.
5. BSNA calls for the appointment of a new nutritional tsar at the heart of government.

About the British Specialist Nutrition Association

BSNA is the trade association representing the manufacturers of products designed to meet the particular nutritional needs of individuals; these include specialist products for infants and young children (including infant formula, follow-on formula, young child formula and complementary weaning foods), medical nutrition products for diagnosed disorders and medical conditions, including parenteral nutrition, and gluten-free foods on prescription. www.bsna.co.uk



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