NETWORK HEALTH DIGEST

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PRESCRIBED ORAL NUTRITIONAL SUPPLEMENTS – BECAUSE THEY'RE WORTH IT?

Oral Nutritional Supplements (ONS) have been a cornerstone of nutritional support for malnourished patients for many years, with huge developments in product variety, taste and nutritional content. Nutritional companies have invested millions in developing products to suit all kinds of age groups, clinical conditions and taste preferences. However, are these products actually beneficial when reducing the long term complications of malnutrition and are they cost effective in tackling this huge health concern?

Malnutrition is a costly business. It's estimated that the health and social care bill as a result of malnutrition is approximately £19.6 billion per year, and that's just for England.[1]

As health and social care budgets are scrutinised and value for money is expected, how can the cost of treatments such as prescribed ONS be justified? The cost of malnutrition swallows up around 15% of total public expenditure for health and social care, with patients over 65 years of age requiring intervention for malnutrition related problems taking up half of this 15%.[1] The pressure is on to manage this effectively and dietetic departments are the baton holders for this activity, equipped with the skills and knowledge to tailor advice and treatment plans for each patients using various tools. Dietitians can chose to implement fortified food/'food first' approaches, prescribed ONS and motivational interviewing/ behaviour change techniques for patients as well as training support for ward and care home staff or carers in order to reach the best treatment plan for each patient.

It is well recognised that prescribed ONS are clinically effective in managing disease related malnutrition. The NICE Quality Standard on Nutrition Support in Adults (QS24)[2] acknowledges that prescribed ONS should be used when food alone is insufficient to meet the dietary needs of a patient. Prescribed ONS should only be given if a patient is unable to reach their daily nutritional requirements through dietary intake alone and/or they are at risk of malnutrition as a consequence of their diagnosis, for example, a disease, condition or their mental health status; or a surgical intervention or treatment, such as chemotherapy. Prescribed ONS may have a role to play in preventing malnutrition prior to some treatments or interventions, for example, prescribed ONS can also be implemented as a prophylactic to maintain a healthy weight and BMI, which may reduce as a result of treatment or surgical intervention.

However, there are huge pressures to reduce the cost of treating malnutrition meaning Dietitians may be restricted in the options available to them

when selecting products to use and there is the ever present issue of limited time available to assess patients as well as. As Dietetic departments experience constrains at a human resources level, the basic assessment for malnourished patients is often the responsibility of ward and care home staff, followed by treatment protocols, which include the next steps for management.This system is only as effective as the nutritional screening tools being used and the training provided to the ward and care staff. However, with these robust measures in place, patients can receive timely ONS, which can reduce the long-term implication of malnutrition. The follow up of these patients is also important to ensure the most appropriate treatment is in place and it is effective. This can pose a problem for Dietetic departments again from a time restraint point of view. However, here there are opportunities for trained Dietetic support staff to review patients or the use of an ongoing ONS review protocol may be implemented. Here patients can be given alternative ONS options if the initial guidance has not been effective.

For example, the initial step on an ONS pathway may be a 'food first' approach, where high calorie, high protein food or fortified foods are offered. This may be suitable for some patients, however, many will need prescribed ONS to ensure they are receiving not only an increase in macronutrients and their micronutrient intake is adequate.

There is limited evidence to suggest that that fortified food is a comparable alternative to prescribed ONS. A systematic review looking at fortified food approaches in comparison to prescribed ONS found that patients given prescribed ONS experienced less postoperative complications, overall infections and falls; and reported an improved quality of life.[3] Use of prescribed ONS can also help to reduce costs and can be cost-effective. Another systematic review looking at the cost and cost effectiveness of using ONS in community and care home settings showed that an average of 9.2% cost saving was demonstrated over 3 months when prescribed ONS were used.[4]

Average savings of 5% were demonstrated by other studies examining the longer-term (3 months or more) cost savings of prescribed ONS use.[5]

In hospital care, prescribed ONS has a role to play in reducing costs again. British Association for Parenteral and Enteral Nutrition (BAPEN) and the National Institute for Health Research Southampton Biomedical Research Centre (NIHR) recently published a report[6] highlighted that the cost of treating or managing a malnourished patient compared to one without malnutrition is significantly higher, three time higher to be exact. The use of prescribed ONS in the hospital setting also greatly influences length of stay. This report demonstrated that prescribed ONS aided a reduction in use of healthcare resources, which could save the NHS £101.8 million each year.

Despite the evidence to support the use of prescribed ONS, some CCGs have implemented significant restrictions for ONS use and prescribing. Some CCGs have developed a prescribing protocol were certain prescribed ONS are considered 'first line' or standard products, followed by other products as second line of treatment or 'last resort' treatments. Some CCGs have even removed certain prescribed products due to cost per unit and are no longer used. To reduce costs, patients may be prescribed one type of ONS, for example, a ready to drink liquid, 1.5 - 2.4kcal per ml type product, yet they may be swapped on to another product when discharged, for example, the 'first line' product may be a powdered shake with 1.6 - 2kcal per ml. These prescribing restrictions can influence the compliance of patients using these products, as they may not always be suitable for their physical or cognitive abilities or lifestyle once discharged from the inpatient setting.

It is important to consider the long-term implications of malnutrition when looking to reduce overall expenditure on prescribed ONS.

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Whilst reducing the options available and restricting products that are more expensive may appear to reduce costs, the impact this may have on the efficacy of the prescribed ONS may not be a positive one. Poor efficacy of prescribed ONS adds to the risk of further malnutrition and the complications it brings, for example, increased risks of hospital admission and readmission, increased infections and falls.

Prescribed ONS plays an effective role in the management of malnutrition, from a clinical outcome, patient care and financial point of view.

Prescribed ONS plays an effective role in the management of malnutrition, from a clinical outcome, patient care and financial point of view. Streamlining and standardising prescribing of ONS is a sensible and cost effective where there are excesses to be trimmed back. The total exclusion or extreme restriction of prescribed ONS is not cost effective and limits optimal patient care. The cost of using prescribed ONS is a contentious issue but in the context of the overall cost of treating and managing malnutrition, it is a positive use of an ever-stretched budget provided it is co-ordinated and managed well.

References:

1. Elia M. The cost of malnutrition in England and potential cost savings from nutritional interventions. Malnutrition Action Group of BAPEN and the National Institute for Health Research Southampton Biomedical Research Centre, 2015
2. NICE Quality Standard on Nutrition Support in Adults (QS24) – available at https://www.nice.org.uk/guidance/qs24 <accessed 23/09/16>
3. Weekes CE et al. A review of the evidence for the impact of improving nutritional care on nutritional and clinical outcomes and cost, Journal of Human Nutrition and Dietetics, 2009; 22 (4): 324–335.
4. Elia M et al. A systematic review of the cost and cost effectiveness of using standard oral nutritional supplements in community and care home settings. Clin Nutr 2016; 35 (1); 125-37.
5. http://www.bsna.co.uk/categories/medical_foods/
6. Elia M. The cost of malnutrition in England, 2015. Ibid

Questions relating to: *Prescribing ONS*
Type your answers below, download and save or print for your records, or print and complete by hand.

Q.1	Explain the cost of malnutrition on the UK's health and social care services.
A	
Q.2	What is involved in reaching the best treatment plan for a patient of malnutrition?
A	
Q.3	What does the NICE Quality Standard on Nutrition Support for Adults acknowledge in respect of ONS prescribing?
A	
Q.4	Discuss some of the difficulties facing dietitians in prescribing of ONS.
A	
Q.5	Explain the 'food first' approach on an ONS pathway for malnutrition management.
A	
Q.6	Describe the benefits of prescribing ONS over fortified foods for the management of malnutrition.
A	
Q.7	Give two examples of how some CCGs have restricted the use and prescribing of ONS.
A	
Q.8	What impact can the restriction of ONS prescribing have on malnutrition management?
A	

Please type additional notes here . . .