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ORAL NUTRITIONAL SUPPLEMENTS (ONS): TO PRESCRIBE OR NOT TO PRESCRIBE?

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The NHS was founded in 1948 with the ambition of bringing good healthcare to all, regardless of wealth. Whilst initially free on the NHS, prescription charges were introduced in 1952. Since then, the availability and cost of prescriptions has been an ongoing topic of change and debate.

NHS England and NICE guidance¹ state that Oral Nutritional Supplements (ONS) should be prescribed 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 which area is dependent on each Clinical Commissioning Group (CCG), the clinically-led statutory bodies that are responsible for the planning and commissioning of health care 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.

WHERE DO ONS FIT IN?

ONS are evidence-based nutritional solutions for disease-related malnutrition.² These highly regulated products³ 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.^{4,6} The NICE Quality Standard on Nutrition Support in Adults (QS24)⁵ 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 to the prevention and management of malnutrition and patients should only be prescribed ONS 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 NICE Clinical Guideline 32,⁴ QS24⁵ and the Managing Adult Malnutrition in the Community Pathway,⁶ this provides the most effective management solution for patients who are malnourished, or at risk of malnutrition. ONS should be discontinued when an individual is no



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longer malnourished, has met their nutritional goal(s) and is able to meet their nutritional needs through food alone.

COST-EFFECTIVENESS

The cost of malnutrition in England is estimated to be £19.6 billion per year, or more than 15% of the total public expenditure on health and social care.⁷ About half of this expenditure is on older people (>65 years).

A British Association for Parenteral and Enteral Nutrition (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.'⁷ 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.

In a systematic review examining the cost and cost effectiveness of using standard ONS in the hospital setting, 12 of 14 cost analyses favoured the ONS group versus no ONS, and among those with quantitative data (12 studies), the mean cost saving was 12.2%.⁸ A meta-analysis showed a mean net cost saving of £746 per patient. Typically, cost savings were associated with significantly improved outcomes; reduced mortality ($P < 0.05$); reduced complications ($P < 0.001$); reduced length of hospital stays (by ~2 days, $P < 0.05$) which corresponded to roughly a 13.0% reduction in hospital stays.

ONS were also found to be cost effective by avoiding development of pressure ulcers and releasing hospital beds in one study and in another by gaining quality adjusted life years. A systematic review examining the cost and cost effectiveness of using ready-to-consume ONS in the community and care home setting demonstrated that ONS

compared to no ONS or routine care produces an overall cost advantage, particularly when used for up to three months (median cost saving of 9.2%; $P < 0.01$).⁹ A median cost saving of ~5% was found for ONS use of ≥ 3 months.

Significant cost savings can be made through the use of ONS as part of a dietary management strategy. 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.⁷ It costs more to treat a malnourished patient than one who is not malnourished.

PREVENTION IS ALWAYS BETTER THAN CURE

The implications of malnutrition are not just to the health and social care bill, but, more importantly, to overall wellness and health outcomes. However, despite growing awareness of the implications of malnutrition, especially in the community setting, there continues to be a lack of support and acknowledgement of those most at risk.

While weight loss and decline in health are aspects of aging, all too often we accept these changes as normal and fail to consider that ensuring sufficient nourishment could delay and diminish these issues, thus prolonging good health for as long as possible: maintenance of a good nutritional status can delay and reduce the risk of developing diseases, help maintain functional independence and, therefore, promote continued independent living.¹⁰ A

recent systematic review, which analysed nine studies, found that ONS in the community reduced hospitalisation by 16.5% ($P < 0.001$).⁹

With age, people naturally tend to eat less. Coupled with numerous variables, such as physiological changes, medications, illness and reduced mobility, it is very likely that shortfalls in micronutrients will arise. Such deficiencies associated with malnutrition can lead to an increased risk of falls, susceptibility to infections and confusion, for example, and result in increased hospital stays and social intervention. The malnourished are also at an increased risk of mortality.^{11,12}

CONCLUSION

Restrictions of ONS are of significant concern and are likely to affect patients' long-term health outcomes. Although CCGs are under increasing pressure to cut costs, a blanket approach is unlikely to be appropriate for all patients in all circumstances. Ensuring the maintenance of nutritional status and thus reducing malnutrition and its associated co-morbidities should be higher up the health agenda.

It is important to consider the long-term health and financial implications of malnutrition when looking at overall prescribed ONS expenditure. The provision of ONS on an FP10 prescription ensures that, under the supervision of a healthcare professional, all patients, including the most vulnerable, are able to access the ONS products that are most appropriate for their care, whenever they are needed.

*For more information and to download our information sheet on the value of ONS see:
www.bsna.co.uk/uploads/files/BSNA_ONS-Document_Oct-2016.pdf*

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