FORGOTTEN NOT FIXED:

It's Time to Tackle the Increasing Burden of Malnutrition in England

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.[1]

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.[1]

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.[2]

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 was placed on prevention and early intervention.

Estimated cost of malnutrition to the public purse in England: £19.6 billion[3]
This represents approximately 15% of overall health and social care expenditure.[3]

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.[3]

It costs more NOT to treat malnutrition than to do so. It is estimated that £5,000 could be saved per patient[3] through better nutrition management.

On average it costs £7,408 per year to care for a malnourished patient, compared to £2,155 for a well-nourished patient[3]

NICE Clinical Guideline 32 on Nutrition Support in Adults (CG32),[4] NICE Quality Standard 24 (QS24),[5] the Managing Adult Malnutrition in the Community Pathway,[6] and the Malnutrition Universal Screening Tool ('MUST')[7] are all tools which could and should be used as a matter of course to manage malnutrition effectively.

New research commissioned by the British Specialist Nutrition Association (BSNA), has found fundamental inconsistencies in the implementation of CG32, QS24 and the other recommended strategies to tackle malnutrition. In addition, there are fundamental inconsistencies in the way that data on malnutrition are collected and reported by individual Trusts meaning 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.

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, and in line with both NHS England guidance[8] and NICE guidance[4,5] oral nutritional supplements (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.

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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. Patients who take ONS should be regularly monitored and reviewed; and ONS should be discontinued when the patient is no longer malnourished, has met their nutritional goal(s) and is able to meet their nutritional needs through food alone. 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%.[9]

In summary:

- Malnutrition remains a significant, growing yet largely preventable problem
- The number of deaths involving malnutrition is rising[2] as are the reported primary and secondary diagnoses of malnutrition. This is despite significant effort to improve clinical practice, most notably NICE CG32 on Nutrition Support for Adults
- The cost of doing nothing significantly outweighs the cost of early intervention, such as dietetic support and provision of ONS if appropriate
- Regional disparities exist in progress made by Trusts in this area
- There are fundamental inconsistencies in the way that data on malnutrition are collected and reported by individual Trusts, meaning that the overall incidence of malnutrition is likely to be significantly under recorded

BSNA calls for:

1 The introduction of a new, comprehensive jointly developed and delivered clinical care pathway for the frail elderly, across all systems.

2 NICE 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) 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 when and 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.

The introduction of a new, comprehensive, jointly developed and delivered clinical care pathway for the frail elderly, across all systems, would go a long way to addressing malnutrition risk. This could include incentives, such as a QOF for malnutrition, and mandatory adherence to CG32 and QS24.

[1] Elia M, Russell CA (eds), Combating malnutrition; Recommendations for Action. A report from the Advisory Group on Malnutrition, led by BAPEN. Redditch: BAPEN, 2009 [2] Office for National Statistics, Deaths from selected causes, by place of death, England and Wales, 2014 to 2015, December 2016 [3] Elia, M, (on behalf of the Malnutrition Action Group of BAPEN and the National Institute for Health Research Southampton Biomedical Research Centre), The cost of malnutrition in England and potential cost savings from nutritional interventions, 2015 [4] NICE, Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition – Clinical Guideline 32 (CG32), 2006 [5] NICE, Nutrition support in adults – Quality Standard 24 (QS24), 2012 [6] Managing Adult Malnutrition in the Community. Oral Nutritional Supplements (ONS). Available at http://malnutritionpathway.co.uk/ons [7] BAPEN, Malnutrition Universal Screening Tool (MUST), 2011 [Available at http://www.bapen.org.uk/pdfs/must/must_full.pdf] [8] NHS England, Guidance on commissioning excellent nutrition and hydration 2015-2018, October 2015 [9] Stratton R., Green C. and Elia M., Disease related malnutrition; an evidence-based approach to treatment, Oxford: CABI, 2003

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