How medical nutrition can save the NHS money

Integrating good nutrition into care pathways, as recommended by NICE Guideline 32,[1] NICE Quality Standard 24,[2] and the NHS England Commissioning Excellent Nutrition and Hydration 2015-18 Guidance,[3] can:

- Encourage self-management of illnesses and long-term conditions
- Relieve pressure on hospitals
- Help secure the sustainability of primary care services
- Support positive health outcomes and reduce costs to the NHS[4,8]

More than three million people in the UK are estimated to be malnourished or at risk of malnutrition.[4] Through increased healthcare interventions, **malnutrition is estimated to cost £19.6 billion in England alone every year, equating to 15% of the total health and social care budget**.[5] **Medical nutrition can help to tackle the long-term challenges faced by the NHS**.

What is medical nutrition?
Medical nutrition, distinct from normal healthy foods, describes a special category of foods designed to meet the needs of patients whose disease or medical disorder requires medically determined nutritional support. Medical foods are scientifically formulated, highly regulated, available on prescription and reimbursed by the NHS. They should be used under medical supervision across a wide range of settings such as hospitals, care homes, clinics and patients' own homes. Medical foods include highly specialised feeds, oral nutritional supplements (ONS) or metabolic products, which can be taken orally as liquids or given as tube feeds. They can be a lifeline for patients of all ages, from infants to the elderly.

Patients requiring medical nutrition range from those with food intolerance and inherited metabolic diseases, to those living with chronic illnesses. These may include cancer, cystic fibrosis, kidney failure or chronic obstructive pulmonary disease (COPD), diseases of the lung, muscular system or heart, as well as psychiatric and neurological conditions.

How can medical nutrition save the NHS money?
Appropriately prescribed specialist medical nutrition can assist patients living with minor illnesses and/or long-term conditions to self-manage their conditions and thus reduce increased and unnecessary pressures on healthcare services. It should be used for the management of disease-related malnutrition whenever patients are unable to meet their nutritional needs through normal foods alone or they are at risk of malnutrition due to surgical intervention or a disease, disorder or medical condition. An integrated programme of medical nutrition has been proven to reduce hospital admissions and readmissions by 30%;[6] reduce average length of hospital stay by 4.5 days and reduce overall complications such as pressure ulcers and infections by over 50%.[7]

It costs more NOT to treat malnutrition than to do so.[4] On average it costs £7,408 each year to care for a malnourished patient, compared to £2,155 for a well-nourished patient.[4] According to the BAPEN/NIHR report published in 2015, 30% of patients admitted to hospital and 35% of those admitted to care homes are malnourished.[9] Oral nutritional supplements are a clinically and cost effective way to manage malnutrition.[4,9]

NICE Clinical Guideline 32 on Nutrition Support in Adults (CG32),[1] NICE Quality Standard 24 (QS24),[2] the Managing Adult Malnutrition in the Community Pathway,[8] and the Malnutrition Universal Screening Tool ('MUST')[11] are all tools which could and should be used as a matter of course to manage malnutrition effectively.

NICE has found that 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.[4] **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**.[4]

However, despite clear evidence to support the cost-effectiveness of medical nutrition in supporting those at risk of malnutrition, some Clinical Commissioning Groups (CCGs) are restricting access to medical nutrition with a view to reducing costs. This not only promotes a "postcode lottery" of healthcare disparity but is also a false economy. Adoption of medical nutrition within patient pathways presents a logical 'invest to save' case by reducing costs including in-patient time, readmissions and complications. By relieving pressure on hospitals and promoting self-management, medical nutrition helps to tackle long-term challenges for the health service, and helps secure the sustainability of the NHS.

What should be done?
BSNA believes that the Government and NHS England should promote greater awareness of good nutritional management and encourage adherence to the recognised standards and guidelines referred to above. They should also ensure that medical nutrition is available to all those who need it, based on patients' individual circumstances. Good nutrition should be an integrated part of all pathways of care, thus minimising inequity of care.

With the right regulatory and commissioning support, innovative health solutions involving medical nutrition can help to improve the quality of life for patients, play a key role in the transition from acute to community care and ensure a sustainable future for the NHS.

footnotes

[1]NICE, Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition – Clinical Guideline 32 (CG32), 2006

[2]NICE, Nutrition support in adults – Quality Standard 24 (QS24), 2012

[3]NHS England, Guidance on Commissioning Excellent Nutrition and Hydration 2015-2018, October 2015.

[4]Elia M, Russell CA (eds), Combating Malnutrition; Recommendations for Action. A report from the Advisory Group on Malnutrition, led by BAPEN. Redditch: BAPEN 2009.

[5]BAPEN and NIHR Southampton, 2015, The cost of malnutrition in England and potential cost savings from nutritional interventions (full report), http://www.bapen.org.uk/pdfs/economic-report-full.pdf p1 (The cost was calculated from the proportion of healthcare activity due to malnutrition and the cost for this activity, which in some cases was uplifted to take into account additional known effects of malnutrition, such as prolongation of length of hospital stay.)

[6]Cawood AL, Elia M, Stratton RJ., 'Systematic review and meta-analysis of the effects of high protein oral nutritional supplements.' Ageing Research Review 2011

[7]Cawood AL, Smith A, Pickles S, Church S, Dalrymple-Smith J, Elia M et al., 'Effectiveness of Implementing 'MUST' into care homes within Peterborough Primary Care Trust, England.' Clinical Nutrition (Supplements) 2010; 4(2):81

[8]BAPEN and NIHR Southampton, 2015, The cost of malnutrition in England and potential cost savings from nutritional interventions (short report), http://www.bapen.org.uk/pdfs/economic-report-short.pdf p4

[9]Stratton RJ and Elia M. A review of reviews: A new look at the evidence for oral nutritional supplements in clinical practice. Clinical Nutrition Supplements 2, 5-23. 2007.

[10]Managing Adult Malnutrition in the Community. Oral Nutritional Supplements (ONS). Available at http://malnutritionpathway.co.uk/ons

[11]BAPEN, Malnutrition Universal Screening Tool (MUST), http://www.bapen.org.uk/pdfs/must/must_full.pdf 2011

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