British Specialist Nutrition Association Ltd

bsna

Forgotten not Fixed: A Blueprint to Tackle the Increasing Burden of Malnutrition in England

Contents

Executive summary

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]

This is unacceptable in any modern healthcare system.

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 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.

Estimated cost of malnutrition to the public purse in England: £19.6 billion[3]

The resulting cost to the public purse is significant. In England alone the costs arising from malnutrition were estimated at £19.6 billion. This represents approximately 15% of overall health and social care expenditure.[3]

It costs more NOT to treat malnutrition than to do so.[3]

It is estimated that £5,000 could be saved per patient through better nutrition management.[3] The provision of nutritional support to 85% of patients at medium to high risk of malnutrition would lead to a cost saving of £325,000 to £432,000 per 100,000 people.[3]

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

Significant cost benefits can be gained from optimal management of nutritional care, not to mention the benefits for patients' quality of life.

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.

However, it appears that there are fundamental inconsistencies in the implementation of CG32, QS24 and the other recommended strategies.

Drawing upon malnutrition data broken down by NHS Trust for 2015/16, new research commissioned by the British Specialist Nutrition Association (BSNA), detailed in this report, has found that more than half of the 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. Against this backdrop, the incidence of malnutrition continues to rise.

Dietitians have an important role to play in finding a solution to this challenge, as they are expertly trained to devise nutritional care plans for patients with medical conditions and help support patients' health and wellbeing.

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.

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]

The cost of doing nothing significantly outweighs the cost of early intervention, such as dietetic support and provision of ONS if appropriate.

New analysis contained in this report demonstrates the need for **CG32 to be made mandatory and for new incentives to be brought forward to transform clinical practice,** since an advisory approach to the identification, recording and management of malnutrition has not been effective.

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

Action is needed to ensure that Trusts are given all the support they need to accurately record malnutrition risk, thus reducing its incidence over time.

The available evidence exemplifies the need for better management of malnutrition and for serious consideration of all possible solutions. In light of this, 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 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) 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 (or equivalent) for malnutrition, and mandatory adherence to CG32 and QS24.

Adherence to nutrition management guidelines

New research commissioned by BSNA explored the current reporting of malnutrition in hospitals in England. Using the latest publicly available data to analyse malnutrition rates across 221 NHS Trusts in England, the research identified Trusts where the recording of malnutrition is significantly below expectation.

The Trusts highlighted in the following map have been identified as having especially poor reporting procedures for malnutrition. This may be as a result of Trusts simply not routinely screening patients for malnutrition, or that they are doing so but failing to use the correct codes to record their findings.

Either way, this gives rise to a sub optimal picture of what is really happening. In all of the Trusts listed below, fewer than 0.05% of finished admission episodes were classified as showing signs of malnutrition, equating to fewer than one in every 2,000 patients.* Official estimates indicate around 2% of malnutrition cases are expected to appear in a hospital setting.[1] Given that more than 3 million people in the UK are expected to suffer from malnutrition,[1] this implies that Trusts in England are not fully capturing the number of patients who are malnourished.

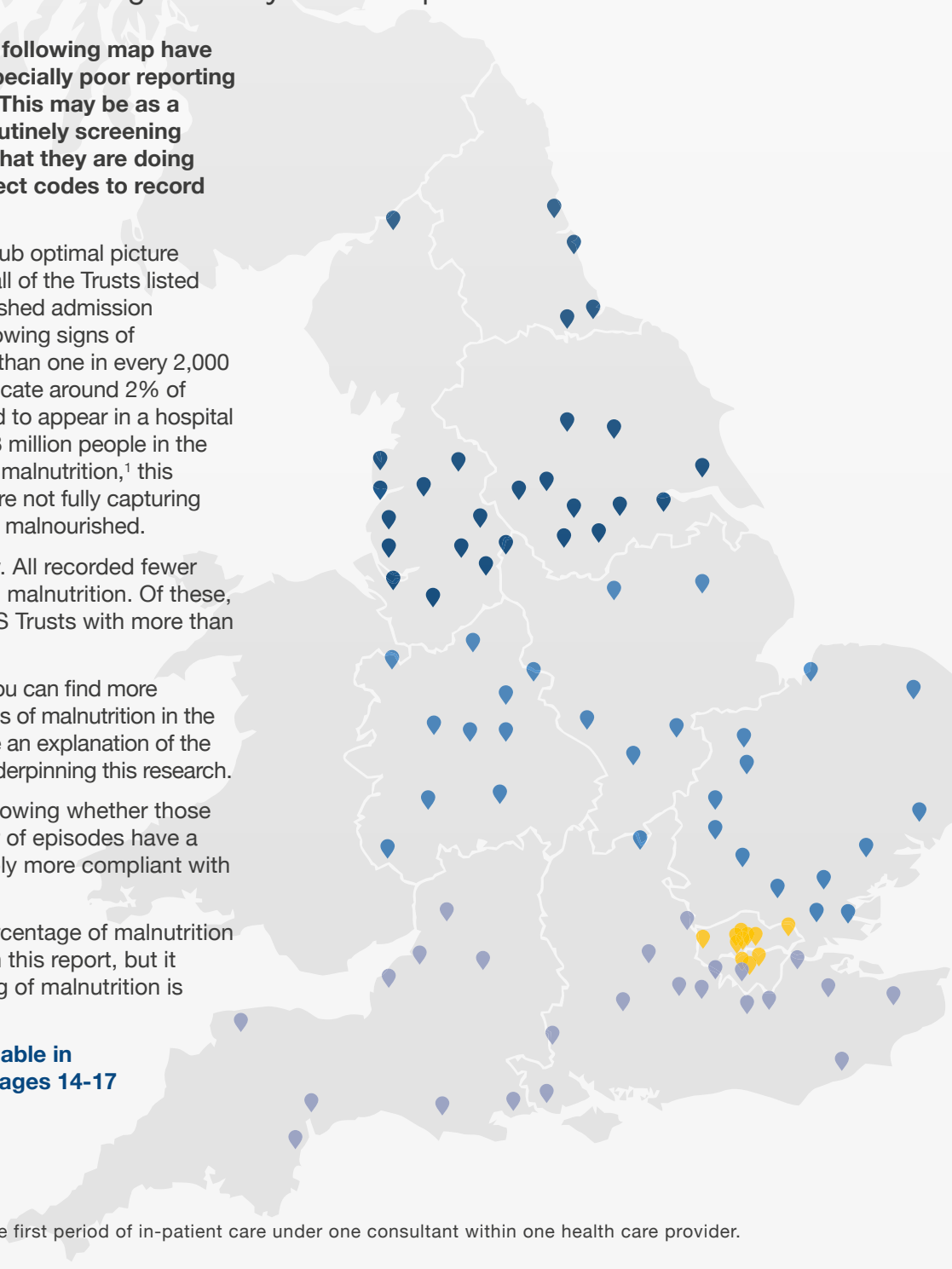
91 NHS Trusts are listed below. All recorded fewer than one in 2,000 patients with malnutrition. Of these, roughly 50% (45) are large NHS Trusts with more than 100,000 admissions per year.

If your local Trust is not listed, you can find more information on its recorded levels of malnutrition in the appendix on page 23, alongside an explanation of the data used and methodology underpinning this research.

There is currently no way of knowing whether those Trusts reporting a high number of episodes have a particular problem, or are simply more compliant with reporting guidelines.

Trusts that have the lowest percentage of malnutrition cases have been highlighted in this report, but it is likely that the under reporting of malnutrition is more widespread.

More detailed maps are available in the centre of this report on pages 14-17



*A finished admission episode is the first period of in-patient care under one consultant within one health care provider.

How you can help

As an MP, there is much that you can do to help secure improved standards of nutritional care for your constituents.

In light of the scale of the problem identified in this report, we would welcome your support to ensure that NICE Clinical Guideline 32 is made mandatory; that incentives such as a QOF (or equivalent) for malnutrition are introduced; and that the management of malnutrition in your local community is improved via implementation of the Managing Adult Malnutrition in the Community Pathway.[6]

You can do this by asking:

- How many people in my constituency have been identified as malnourished or at risk of malnutrition in the last year?
- What steps is the Government taking to combat malnutrition specifically in acute and community settings, and how does this compare to other analogous conditions, such as obesity?
- What assessment has the Government made of the success of the NICE Clinical Guideline in tackling malnutrition?
- Will the Government introduce incentives for encouraging nutritional screening (and associated care plan according to malnutrition risk identified) in acute and community care, including incentives in the Quality and Outcomes Framework of the GP contract (for example) or its successor?
- What assessment has the Government made of the inspection regime for the NHS and social services (hospital, care home, primary care and domiciliary care inspections), overseen by the Care Quality Commission and is it robust in relation to inspecting care providers for delivering high-quality nutritional care in all care settings?

Malnutrition has serious implications for patients, and it is essential that Trusts are held to account to ensure that the picture improves.

You can help by asking your local Trust:

- How prevalent is malnutrition in your patients?
- What tools does the Trust use to screen and monitor those at risk of malnutrition?
- Does the Trust screen all in-patients on admission and all out-patients at their first clinic appointment for malnutrition using 'MUST' or a similar nationally validated nutrition screening tool, in line with the NICE guideline?
- How many specialist nutrition nurses and dietitians does the Trust employ?
- Does the Trust have a nutrition steering committee? Is there such a committee in the hospital or community?
- Does the Trust incorporate nutrition information in the discharge summary?

You can ask your CCG:

- What measures are currently in place to identify and manage malnutrition?
- Are Oral Nutritional Supplements (ONS) available on prescription for all patients who clinically need them?
- Are patients who are at risk of malnutrition monitored and reviewed?
- Who manages patient care plans in your local area?
- What steps are being taken to encourage GPs to identify and manage malnutrition?
- How are malnutrition and dehydration measured and monitored?
- How are the costs and implications of malnutrition monitored?
- Has the burden of malnutrition on the local community been assessed?
- How many practising community dietitians are there locally?
- Who is the designated clinical lead for nutrition and hydration?
- When there is a change in local nutrition/ONS prescribing policy/guidelines, is an impact assessment evaluation carried out 6-12 months following implementation? If so, what does the 'impact assessment evaluation' include? E.g. is the healthcare use of ONS monitored in terms of patient experience and quality of life?
- How is the local community informed about good nutrition?

Over 98% of malnutrition exists outside of hospital,[1] meaning that your local Clinical Commissioning Group (CCG) also has an important role to play.

Main Report

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Reporting, data and management
NHS Trust Maps
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Introduction to malnutrition and its impact

The importance of good nutrition should not be understated. Whilst considerable focus has been given to obesity in recent times, including high profile policy interventions, All Party Parliamentary Group (APPG) enquiries and General Election manifesto pledges, malnutrition still remains the poor relation, notwithstanding the size and scale of the problem.

Yet obesity and malnutrition are both states on the nutritional spectrum and the goal of public health intervention should be to ensure good nutritional status for the population as a whole, particularly for those individuals at risk of malnutrition.

More than three million people in the UK are estimated to be 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 either be malnourished or at risk of malnutrition.[1] This is despite the existence of guidelines from the National Institute for Health and Care Excellence (NICE) and NHS England on the identification and management of malnutrition.[4,5]

Malnutrition occurs when the body is not getting enough of the nutrients it needs to stay healthy and can develop if a person is unable to eat properly, or if the body needs more nutrients than normal, for example as a result of an operation, chronic disease or infection.

Malnutrition can have an impact on both physical and mental health. As a result, malnourished people suffer a range of symptoms and have disproportionately high healthcare requirements.

Estimated cost of malnutrition to the public purse: £19.6bn[3]

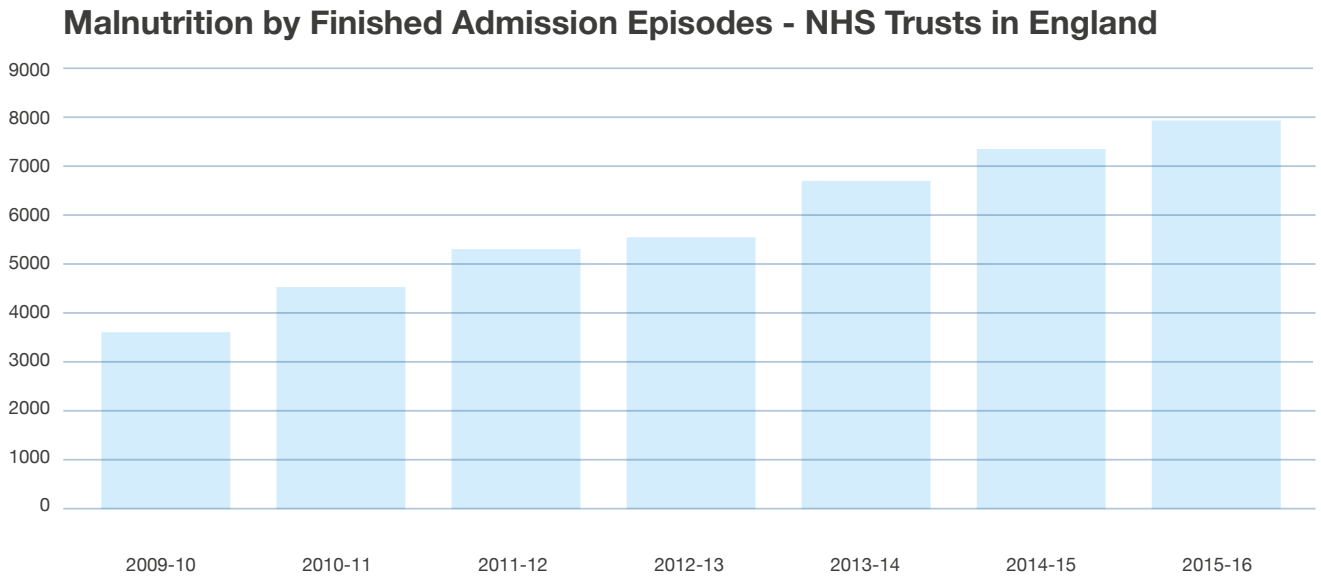
The cost of malnutrition to the public purse is significant. In 2011/12, malnutrition was estimated to cost £19.6bn in health and social care services in England alone, representing approximately 15% of overall health expenditure.[3] It is likely to have risen considerably in the years since then.

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

As recently highlighted in parliament,[10] the number of deaths from underlying malnutrition, or where malnutrition was named as a contributory factor, increased from 268 in 2007 to 351 in 2016 – an increase of more than 30% in the past decade.[2] The number of admissions to hospital where malnutrition was a factor also increased.[11] See graph one for information on the year on year increase.

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]

The impact on local areas is considerable, since 93% of malnutrition is estimated to occur in community settings. However, the largest cost comes from the management of malnourished people in hospitals, even though they only account for 2% of cases.[1] 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.



Graph one[11]

Guidance exists that should be followed in all care settings. NICE Clinical Guideline 32 on Nutrition Support in Adults (CG32),[4] accompanied by NICE Quality Standard 24 (QS24),[5] sets the standard for appropriate and timely nutritional care in this context. These are supported by the Managing Adult Malnutrition in the Community Pathway,[6] an evidence based tool 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) and Royal College of General Practitioners (RCGP).

The Malnutrition Universal Screening Tool ('MUST') 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 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.

In order to be tackled effectively, malnutrition needs to be screened, identified and managed effectively and appropriately. Malnutrition remains a growing problem, yet is largely preventable and can be better managed if the right guidance is followed.

Reporting, data and management

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.

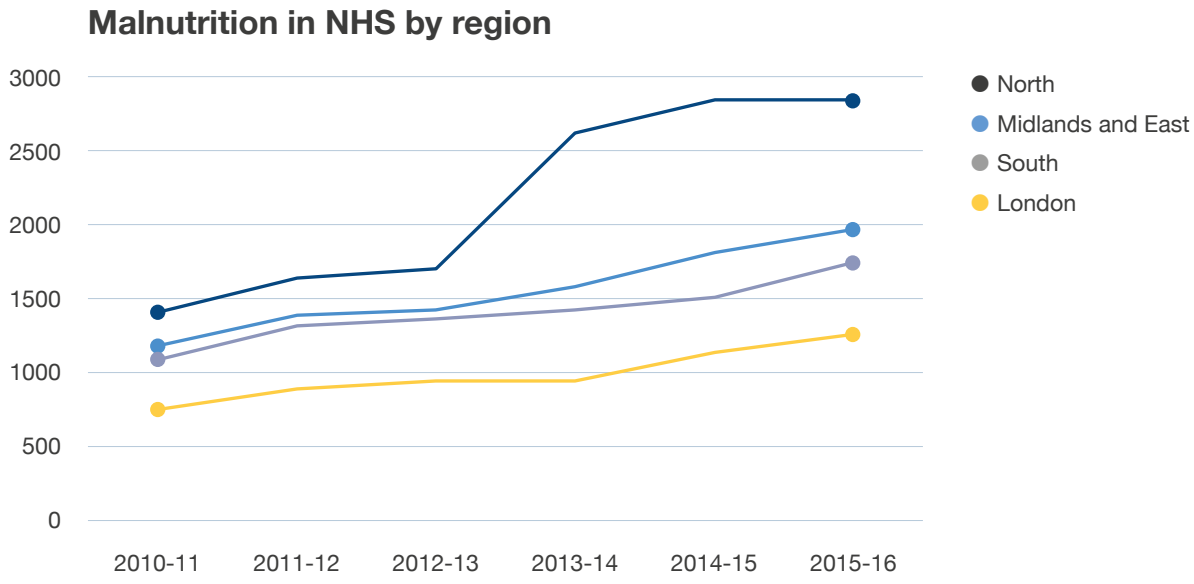
In answer to a recent parliamentary question lodged with the intention to scrutinise action on malnutrition, Health Minister Stephen Barclay MP revealed that official figures on the cost of malnutrition to the NHS are "not held centrally".[12] This is consistent with a parliamentary response given in March 2016 by the former Public Health Minister, indicating that over the past two years limited progress has been made in the collection of data on the impact of malnutrition.

"Information on the estimate of the cost to the NHS of malnutrition amongst adults is not available centrally."
Jane Ellison, Public Health Minister, 24 March 2016.[13]

Were the Quality Standard and the full accompanying Clinical Guideline (CG32) 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.

Malnutrition data broken down by NHS Trust is the only localised breakdown of malnutrition data publicly available. Although NHS Trusts cannot be mapped to a specific local footprint, because patients will not always attend their nearest hospital, data on them can be used to illustrate trends by region and to identify local hospital activity.

Grouping trusts by region (graph two), the data show an upward trend for cases of malnutrition by finished admission episodes (FAE) is common across England.



Graph two - Map showing the rate of Finished Admission Episodes involving either a primary or secondary diagnosis of malnutrition in NHS Trusts in England, split by region from 2010-2016[11,15]

FAEs by region in 2015/16

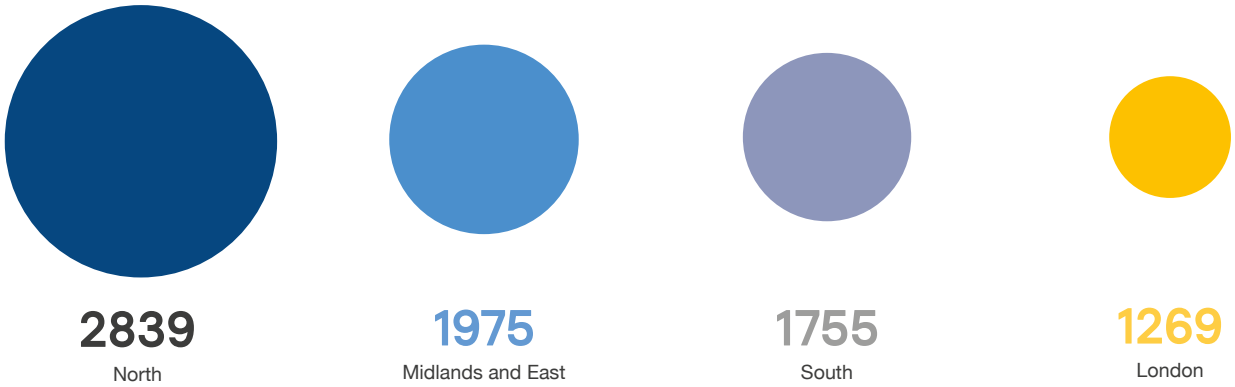


Fig. one[11,15]

This data demonstrates that malnutrition remains a significant and growing problem despite significant efforts to improve clinical practice, including the existence of CG32.

Significant regional disparities exist in progress made by Trusts. It is possible that particular initiatives, including a number of vanguard sites, in the North have led to raised local awareness, more comprehensive screening of patients and better reporting of malnutrition.

In many instances, it seems likely that higher reported levels of malnutrition indicate better reporting procedures, rather than a higher regional incidence rate. For example, a Trust such as Wirral University Teaching Hospital NHS Foundation Trust reported 586 cases of malnutrition in 2015/16, compared to just 21 cases in 2009/10. This increase – nearly thirty times over a six-year period – was highlighted in a parliamentary debate on malnutrition in December 2017.[14] The increase could be explained by a number of factors, but is it likely that effective reporting procedures in place at the Trust means that patients showing signs of malnutrition have been identified.

The Government position supports this, with the former Public Health Minister stating in 2016 that "apparent increases in activity may be due to improved recording of diagnosis or procedure information".[13]

However, inconsistencies appear to be present in the data, as detailed in the discussion on methodology in this report's appendix, which suggests that reported levels of malnutrition may not accurately reflect the reality.

For this reason, Trusts with the highest recorded incidence of malnutrition have not been highlighted in this report.

Without consistent data, levels of malnutrition cannot be accurately scrutinised and addressed. Health and care providers appear not to be recording malnutrition effectively, suggesting that advisory guidelines are not being followed. The analysis below, considered alongside the paucity of the data, shows hundreds of admissions per year may be being excluded from analysis of malnutrition cases by locality.

A lack of correct reporting and/or coding may reflect inconsistent implementation of CG32 and QS24. It is clear, therefore, that further action needs to be taken in order to address malnutrition effectively.

BSNA is calling for CG32 to be made mandatory and for the Government to go further by considering bringing forward incentives to drive improvement in this important area. The development of new incentives to transform clinical practice, including how malnutrition is identified, recorded and managed should also be discussed.

NHS Trust maps

The breakdown of malnutrition admission episodes by NHS Trust highlights the areas that have failed to implement the recommended reporting procedures, and which would most benefit from mandatory guidance and incentives to help address malnutrition in their patient population.

For this report, analysis was undertaken using the latest publicly available malnutrition data from 221 NHS trusts, covering the period 2015/16. The recorded malnutrition data was then displayed as a percentage of the finished admission episodes (FAEs) in each Trust.

Children's hospitals have been excluded from the data. Trusts recording less than 20,000 FAEs in 2015/16 have also been excluded. Many of those with less than 20,000 FAEs across a twelve-month period are smaller hospitals, offering specialist services such as orthopaedics and mental health.

An FAE is the first period of in-patient care under one consultant within one healthcare provider. FAEs are counted against the year in which the admission episode finishes. Admissions do not represent the number of patients, as a person may have more than one admission within a twelve-month period.

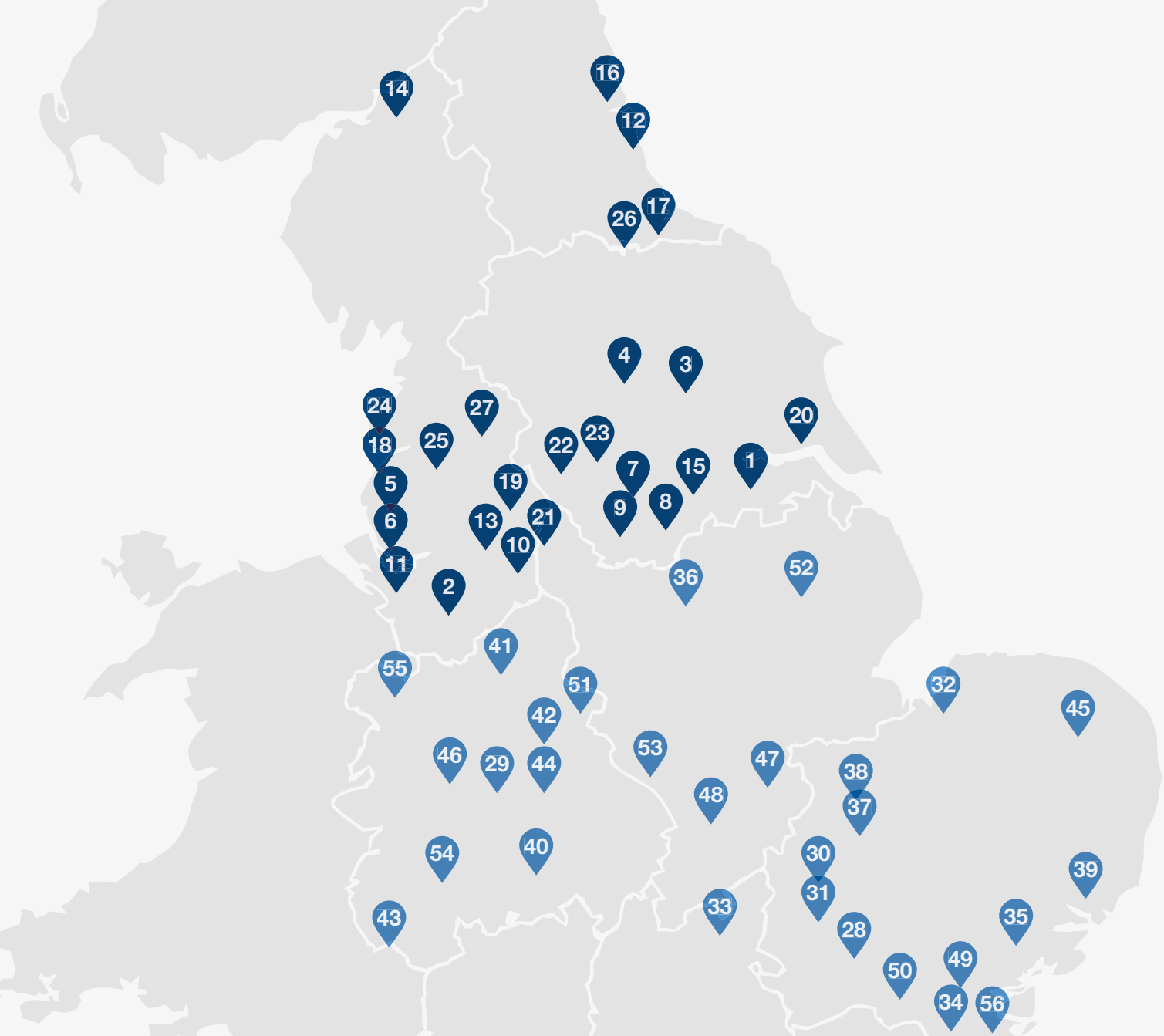
In all of the Trusts listed below, fewer than 0.05% of admissions were classified as showing signs of malnutrition, equating to fewer than one in every 2,000 patients. Official estimates indicate around 2% of malnutrition cases are expected to appear in a hospital setting.[1] This implies that Trusts are not fully capturing the number of patients who are malnourished.

The evidence from the Trusts below further supports the requirement for the NICE CG32 to be made mandatory and for the introduction of incentives for the screening, reporting and appropriate management of malnutrition.

Trusts that reported fewer than one in 2,000 patients with malnutrition in 2015/16 – broken down by region and with parliamentary constituency added

North – 27 Trusts

1. Northern Lincolnshire and Goole NHS Foundation Trust – Scunthorpe
2. Mid Cheshire Hospitals NHS Foundation Trust – Eddisbury
3. York Teaching Hospital NHS Foundation Trust – York Central
4. Harrogate and District NHS Foundation Trust – Harrogate and Knaresborough
5. Aintree University Hospital NHS Foundation Trust – Liverpool, Walton
6. Liverpool Women's NHS Foundation Trust – Liverpool, Riverside
7. Barnsley Hospital NHS Foundation Trust – Barnsley Central
8. The Rotherham NHS Foundation Trust – Rotherham
9. Sheffield Teaching Hospitals NHS Foundation Trust – Sheffield Central
10. East Cheshire NHS Trust – Macclesfield
11. Countess of Chester Hospital NHS Foundation Trust – City of Chester
12. City Hospitals Sunderland NHS Foundation Trust – Sunderland Central
13. University Hospital of South Manchester NHS Foundation Trust – Wythenshawe And Sale East
14. North Cumbria University Hospitals NHS Trust – Carlisle
15. Doncaster and Bassetlaw Hospitals NHS Foundation Trust – Doncaster Central
16. The Newcastle Upon Tyne Hospitals NHS Foundation Trust – Newcastle Upon Tyne East
17. South Tees Hospitals NHS Foundation Trust – Middlesbrough
18. Southport and Ormskirk Hospital NHS Trust – Southport
19. Central Manchester University Hospitals NHS Foundation Trust – Manchester Central
20. Hull and East Yorkshire Hospitals NHS Trust – Kingston Upon Hull West
21. Stockport NHS Foundation Trust – Cheadle
22. Calderdale and Huddersfield NHS Foundation Trust- Colne Valley
23. Mid Yorkshire Hospitals NHS Trust – Wakefield
24. Blackpool Teaching Hospitals NHS Foundation Trust – Blackpool North And Cleveleys
25. Lancashire Teaching Hospitals NHS Foundation Trust – Chorley
26. County Durham And Darlington NHS Foundation Trust – Darlington
27. East Lancashire Hospitals NHS Trust – Burnley



Midlands & East – 29 Trusts

28 East and North Hertfordshire NHS Trust – Stevenage

29 Heart of England NHS Foundation Trust – Birmingham, Hodge Hill

30 Bedford Hospital NHS Trust – Bedford

31 Luton and Dunstable University Hospital NHS Foundation Trust – Luton North

32 The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust – North West Norfolk

33 Milton Keynes University Hospital NHS Foundation Trust – Milton Keynes South

34 Basildon and Thurrock University Hospitals NHS Foundation Trust – South Basildon and East Thurrock

35 Colchester Hospital University NHS Foundation Trust – Colchester

36 Chesterfield Royal Hospital NHS Foundation Trust – Chesterfield

37 Papworth Hospital NHS Foundation Trust – South Cambridgeshire

38 Peterborough and Stamford Hospitals NHS Foundation Trust – Huntingdon

39 Ipswich Hospital NHS Trust – Ipswich

40 South Warwickshire NHS Foundation Trust – Warwick and Leamington

41 University Hospitals of North Midlands NHS Trust – Stoke On Trent Central

42 Burton Hospitals NHS Foundation Trust – Burton

43 Wye Valley NHS Trust – Hereford and South Herefordshire

44 George Eliot Hospital NHS Trust – Nuneaton

45 Norfolk and Norwich University Hospitals NHS Foundation Trust – South Norfolk

46 The Dudley Group NHS Foundation Trust – Dudley North

47 Kettering General Hospital NHS Foundation Trust – Kettering

48 Northampton General Hospital NHS Trust – Northampton South

49 Mid Essex Hospital Services NHS Trust – Chelmsford

50 The Princess Alexandra Hospital NHS Trust – Harlow

51 Derby Teaching Hospitals NHS Foundation Trust – Derby North

52 United Lincolnshire Hospitals NHS Trust – Lincoln

53 University Hospitals of Leicester NHS Trust – Leicester West

54 Worcestershire Acute Hospitals NHS Trust – Worcester

55 Shrewsbury and Telford Hospital NHS Trust – Shrewsbury and Atcham

56 Southend University Hospital NHS Foundation Trust – Southend West

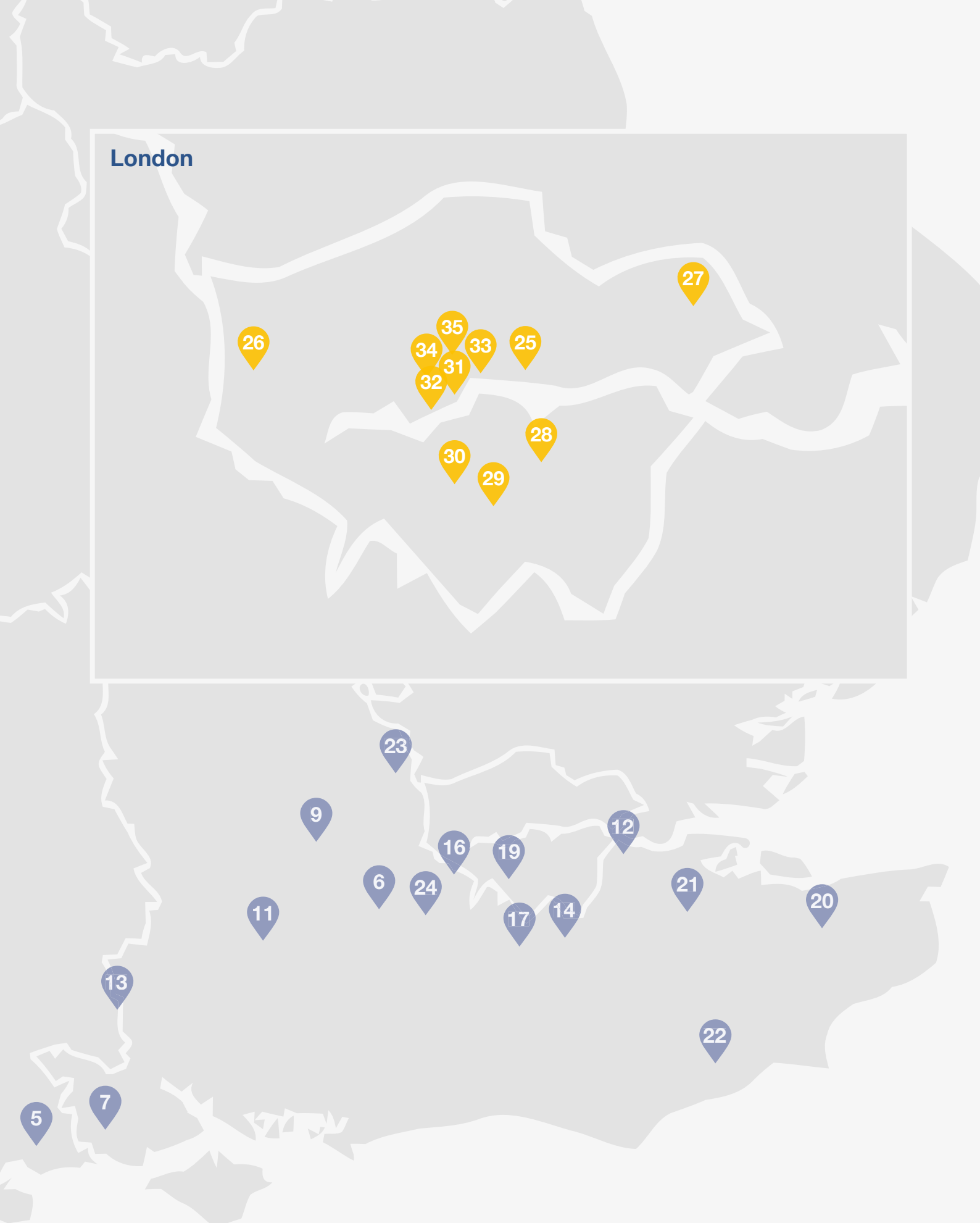
South – 24 Trusts

1 Torbay and Southern Devon Health and Care NHS Trust – Torbay
2 Weston Area Health NHS Trust – Weston-Super-Mare
3 Dorset County Hospital NHS Foundation Trust – West Dorset
4 Northern Devon Healthcare NHS Trust – North Devon
5 Poole Hospital NHS Foundation Trust – Poole
6 Frimley Health NHS Foundation Trust – Surrey Heath
7 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust – Bournemouth East
8 Royal Devon and Exeter NHS Foundation Trust – East Devon
9 Royal Berkshire NHS Foundation Trust – Reading East
10 Great Western Hospitals NHS Foundation Trust – South Swindon
11 Hampshire Hospitals NHS Foundation Trust – Basingstoke
12 Dartford and Gravesham NHS Trust – Dartford
13 Salisbury NHS Foundation Trust – Salisbury
14 Queen Victoria Hospital NHS Foundation Trust – Mid Sussex
15 Gloucestershire Hospitals NHS Foundation Trust – Cheltenham
16 Ashford and St Peter's Hospitals NHS Foundation Trust – Runnymede and Weybridge
17 Surrey and Sussex Healthcare NHS Trust – Reigate
18 North Bristol NHS Trust – Bristol North West
19 Epsom and St Helier University Hospitals NHS Trust – Carshalton and Wallington
20 East Kent Hospitals University NHS Foundation Trust – Canterbury
21 Maidstone and Tunbridge Wells NHS Trust – Maidstone and The Weald
22 East Sussex Healthcare NHS Trust – Hastings and Rye
23 Buckinghamshire Healthcare NHS Trust – Chesham and Amersham
24 Royal Surrey County Hospital NHS Foundation Trust – Guildford

London – 11 Trusts

25 Barts Health NHS Trust – Bethnal Green and Bow
26 The Hillingdon Hospitals NHS Foundation Trust – Uxbridge and South Ruislip
27 Barking, Havering and Redbridge University Hospitals NHS Trust – Romford
28 Lewisham and Greenwich NHS Trust – Lewisham, Deptford
29 Croydon Health Services NHS Trust – Croydon North
30 St George's University Hospitals NHS Foundation Trust – Tooting
31 The Royal Marsden NHS Foundation Trust – Chelsea and Fulham
32 Chelsea and Westminster Hospital NHS Foundation Trust – Chelsea and Fulham
33 University College London Hospitals NHS Foundation Trust – Holborn and St Pancras
34 Royal Brompton and Harefield NHS Foundation Trust – Chelsea and Fulham
35 Imperial College Healthcare NHS Trust – Cities Of London and Westminster

Local Trust not listed? A full breakdown of malnutrition episodes by NHS Trust from 2009-2016 can be found in the Appendix – see how yours compares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The Trusts listed above are split evenly across the regions of England, indicating a systemic under reporting of malnutrition. However, it is not possible to extrapolate from the available data whether this is because of full or partial adherence to the available guidance. Of the 221 Trusts analysed for this report, almost all reported fewer than one case of malnutrition for every 100 patients admitted. It is therefore likely that many, if not all, Trusts need to improve the process by which malnutrition risk is identified and coded.

The statistics are at considerable variance with the generally accepted estimated prevalence of malnutrition in the UK, suggesting that they vastly under-represent the hospital population that could be expected to be affected by, or at risk of, malnutrition.

Over and above the picture of varied reporting, the figures also illustrate an upward trend of incidence of malnutrition across all parts of England. The increasing number of cases of malnutrition in hospital and associated increase in deaths from malnutrition suggest a failure to consistently prevent, screen and manage the condition.

Malnutrition is an avoidable cost to the NHS, but remains a significant and growing problem. Efforts to improve clinical practice have not resulted in adherence to clinical guidelines and there are fundamental inconsistencies in data collection, which means the overall incidence of malnutrition is likely to be significantly under recorded.

NICE CG32 must be made mandatory and incentives (such as a QOF or its equivalent for malnutrition) should be considered to transform clinical practice. Inadequate management of malnutrition cannot and should not be tolerated in any modern healthcare system.

What can be done?

Prevention and appropriate management have an important role to play in addressing the challenges presented by malnutrition. NICE CG32 includes a range of measures that can be taken to address malnutrition and its impact on patients, as does the NHS England guidance on commissioning excellent nutrition and hydration 2015-2018.[8]

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.[3]

Better awareness, consistent screening and reporting of malnutrition are essential. However, in order to achieve the desired step change in approach, incentives and mandatory adherence to CG32/QS24 must now be considered. Without such initiatives, the situation is unlikely to change.

Ensuring that patients receive adequate nutritional intake is essential for improving health outcomes. Whilst a nutritious diet is essential to avoid malnutrition, it is not always possible for people to eat enough food or ingest the nutrients they need to stay healthy. Effective management, as illustrated by the Managing Adult Malnutrition Pathway,[6] is integral to addressing malnutrition in those individuals at risk of, or suffering from, malnutrition.

In light of this, BSNA is calling for more investment in community dietitians, as they are expertly trained to devise nutritional care plans for patients with medical conditions and help support patients' health and wellbeing. Clearly identified care pathways, including review and monitoring by healthcare professionals, are required to ensure patients receive appropriate care.

When appropriate, Oral Nutritional Supplements (ONS) can be prescribed to ensure that patients are adequately cared for and that further complications do not arise. ONS are specially formulated products which contain energy, protein, fat, carbohydrate, vitamins and minerals. They can partially supplement or, in certain medical conditions, wholly replace, a normal diet to provide patients with the essential nutrients they need when food alone is insufficient to meet their daily nutritional requirements. These individuals may include those recovering from surgery, suffering from cancer, renal failure, cerebral palsy, cystic fibrosis, or poor wound healing or those who have suffered a stroke. In such cases, patients may find it difficult to eat adequate amounts of food owing to loss of appetite, the side effects of treatment or an inability to safely chew or swallow normal food. If this is the case, ONS may be required alongside food to support recovery and avoid malnutrition: 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.

ONS are already used to a greater or lesser extent across the country to support those suffering from, or at risk of, malnutrition. The appropriate use of preventative measures and management such as ONS can lead to an improved quality of life for at-risk groups,[6] as they can support wound healing, maintain muscle strength, support recovery from illness and optimise immune responses. Improved nutrition in elderly patients is likely to help reduce the burden on social care by increasing levels of mobility and independence.

There is little evidence of efficacy of managing disease related malnutrition with food-based strategies alone compared to the use of ONS.[16] Yet despite this, against a backdrop of increasing cost pressures on the NHS, a number of 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.[17]

The cost of doing nothing significantly outweighs the cost of early intervention, such as dietetic support and provision of ONS if appropriate.

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. This could include incentives, such as a QOF (or equivalent) for malnutrition, and mandatory adherence to NICE CG32 and QS24.

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.

The use of ONS as part of a dietary management strategy can produce significant cost savings.[1, 3]

BAPEN estimates that the appropriate oral nutritional support in both prevention and management could:

- Save the NHS £101.8 million per year[3]
- Help to alleviate pressure on both primary and secondary care
- Reduce GP visits, which, alone could save the NHS £3.9 million in England[1]

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.[3]

In summary, prevention and treatment of malnutrition requires initial outlay and early action to reduce the risk and cost of longer-term complications. Healthcare professionals, commissioners and policymakers across all settings must balance investment in ONS and dietetic services against consideration of longer term burdens to both patients and the NHS that can be exacerbated without action.

Recommendations

The available evidence exemplifies the need for earlier identification and better management of malnutrition and for serious consideration of the available solutions. Malnutrition is both a risk factor for, and consequence of, disease which costs the NHS and social services tens of billions of pounds per year.

In light of this, 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 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**
- **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 reviewed and monitored by a healthcare professional.

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Appendix

Note on available data and methodology followed

The data used in this report is the best available for public scrutiny. Whilst further data may exist for NHS audiences, no further data has been identified that could be used to scrutinise performance on nutrition management in England.

The tables below show the raw data, sourced from NHS Digital, on finished admission episode by NHS Trust from 2009-2016, which have been grouped by region.

The original data source can be found at: NHS Digital, Malnutrition figures by provider, 14 December 2016. - http://content.digital.nhs.uk/media/23157/Malnutrition-figures-by-provider/xls/malnutrition_by_provider_suppressed_141216.xlsx (Accessed 12 January 2018)

To protect patient confidentiality, figures between 1 and 5 are replaced with "*" (an asterisk) in NHS Trust data. Analysis for this report substituted this with 2.5 to provide an informed estimate.

The report is only as robust as the available data, from which relevant conclusions have been drawn.

Note on constituencies highlighted by the maps

Since NHS Trusts cannot be mapped to an exact footprint, constituencies are identified by the main registered address. In reality neighbouring constituencies will also be affected by poor screening and reporting since patients often cross constituency boundaries to access the relevant care.

Note on inconsistencies in the available data

Included diagnoses

The country wide Hospital Episode Statistics (HES),[1] which malnutrition data is drawn from, includes a number of listed diagnoses that represent cases of malnutrition which are not counted. The diagnoses included, and therefore counted in the statistics, split by provider are:

- Protein-energy malnutrition of moderate and mild degree
- Retarded development following protein-energy malnutrition
- Unspecified protein-energy malnutrition
- Unspecified severe protein-energy malnutrition
- Malnutrition in pregnancy
- Kwashiorkor
- Nutritional marasmus
- Marasmic kwashiorkor

However, HES also capture the following diagnoses which are not counted in the analysis of malnutrition by locality:

- Effects of hunger
- Imbalance of constituents of food intake
- Insufficient intake of food and water due to self-neglect
- Other symptoms and signs concerning food and fluid intake

This means hundreds of admissions per year may be excluded from analysis of malnutrition cases by locality.

Consistency of the statistics with accepted estimates

Furthermore, given the estimated prevalence of malnutrition in the UK, the statistics vastly under-represent the hospital population that could be expected to be affected.

Since more than three million people in the UK are estimated to be affected by malnutrition,[1] approximately 2.5 million could be expected to be in England based on ONS population estimates.[1]

Although 2% of malnutrition cases are estimated to occur in hospital, with 93% occurring in the community and 5% in care homes, 2% of this estimate for England should still total approximately 50,000 patients.

However, the total number of finished hospital admission episodes with a diagnosis of malnutrition is recorded at around 7,800 in 2015/16.[1] The hospital statistics therefore appear to be incomplete.

Although the estimated figures also include the estimate of people at risk of malnutrition, not just current sufferers, the Trust statistics account for individual admissions episodes, so may regularly represent repeated episodes involving the same individual. The Trust statistics are therefore likely to under-represent the prevalence of malnutrition overall.

Table of finished admissions episodes involving malnutrition reported by NHS Trusts in England

The tables below show the raw data, sourced from NHS Digital, on finished admission episode by NHS Trust from 2009-2016, which have been grouped by region.

Provider Trust		2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
RTQ	2GETHER NHS FOUNDATION TRUST	0	0	0	0	0	*	0
RTV	5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	*	0	0	0	0	*	*
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	29	13	20	33	46	31	36
RCF	AIREDALE NHS FOUNDATION TRUST	9	15	31	21	38	58	78
RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	*	8	*	0	*	*	6
RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	9	19	19	38	23	21	16
RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	14	17	27	29	35	47	55
RVL	BARNET AND CHASE FARM HOSPITALS NHS TRUST	28	30	37	21	20	18	0
RRP	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	0	0	*	0	*	0	*
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	8	9	13	6	6	10	21
RNJ	BARTS AND THE LONDON NHS TRUST	28	45	32	0	0	0	0
R1H	BARTS HEALTH NHS TRUST	0	0	0	78	97	102	96
RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	8	19	16	23	31	44	31
RC1	BEDFORD HOSPITAL NHS TRUST	17	10	13	21	29	28	27
RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	0	0	*	0	0	0	*
RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	0	0	0	0	*	0	*
RQ3	BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	8	9	17	13	11	20	16
RYW	BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	0	*	*	10	*	*	*
RXKTC	BIRMINGHAM TREATMENT CENTRE	*	0	0	0	0	0	0
RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	10	20	14	24	46	30	34
RMC	BOLTON NHS FOUNDATION TRUST	17	41	60	68	95	71	71
RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	65	101	136	100	78	79	67
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	30	60	72	72	75	65	74
RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	6	10	9	22	15	22	15
RJF	BURTON HOSPITALS NHS FOUNDATION TRUST	7	*	11	13	19	9	8
RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	7	20	11	22	17	16	15
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	25	34	24	38	53	72	108
RV3	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	0	0	0	0	*	*	0
RW3-X	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	31	46	55	79	65	68	55
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	12	27	28	25	25	28	53

Provider Trust		2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	7	11	18	10	20	30	27
RLN	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	8	14	23	28	15	7	33
RDE	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	37	20	32	16	26	37	39
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	0	0	*	*	*	*	*
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	17	12	20	14	23	24	23
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	23	23	22	26	25	22	19
RYG	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	0	*	0	0	0	0	*
RJ6	CROYDON HEALTH SERVICES NHS TRUST	12	16	21	23	14	*	20
RNN	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	0	0	*	*	*	*	*
RN7-X	DARTFORD AND GRAVESHAM NHS TRUST	*	15	8	10	11	*	18
RTG	DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST	16	25	29	26	31	46	37
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	0	0	*	*	*	*	*
RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	0	0	0	0	0	*	*
RWV	DEVON PARTNERSHIP NHS TRUST	0	*	0	0	0	0	0
RP5	DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	24	30	41	50	30	41	55
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	28	11	12	23	15	17	16
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	*	*	*	*	10	24
RC3	EALING HOSPITAL NHS TRUST	16	7	11	18	29	0	0
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	13	15	22	18	6	8	19
RJN	EAST CHESHIRE NHS TRUST	11	18	15	12	19	9	10
RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	19	23	22	29	22	26	27
RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	33	29	28	20	21	24	43
RWK	EAST LONDON NHS FOUNDATION TRUST	*	0	0	0	*	0	0
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	19	12	43	28	21	10	29
RVR-X	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	24	27	30	27	25	19	41
RDU	FRIMLEY HEALTH NHS FOUNDATION TRUST	14	19	19	21	42	47	37
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	37	0	0	0	0	0	0
RR7-X	GATESHEAD HEALTH NHS FOUNDATION TRUST	0	56	57	44	65	30	67
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	16	14	20	9	18	11	13
R1J	GLOUCESTERSHIRE CARE SERVICES NHS TRUST	0	0	0	0	*	6	*
RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	27	44	43	36	30	33	36
RP4	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	15	22	11	31	16	32	18
RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	21	33	46	36	16	22	23

Provider Trust		2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
RXV	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	0	0	0	*	*	*	0
RJ1-X	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	37	38	30	31	34	59	185
RN5-X	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	8	15	20	25	28	47	47
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	*	16	11	11	20	20	15
RR1-X	HEART OF ENGLAND NHS FOUNDATION TRUST	58	71	85	66	52	56	62
RD7	HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST	14	19	15	10	9	17	0
RY4	HERTFORDSHIRE COMMUNITY NHS TRUST	0	*	0	0	0	*	0
RWR	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	0	0	0	0	0	0	*
RQQ-X	HINCHINGBROOKE HEALTH CARE NHS TRUST	6	7	11	6	17	8	11
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	30	19	29	27	34	32	55
RWA	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	20	30	46	39	33	23	42
RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	52	63	111	97	109	184	122
RGQ	IPSWICH HOSPITAL NHS TRUST	20	16	30	36	21	21	27
R1F-X	ISLE OF WIGHT NHS TRUST	0	0	0	25	25	18	30
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	30	27	31	31	36	26	37
RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	0	0	0	0	*	0	*
RYY	KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	0	0	0	*	0	*	*
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	9	9	*	6	10	35	25
RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	25	63	53	48	103	123	129
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST	14	25	24	15	19	18	55
RW5	LANCASHIRE CARE NHS FOUNDATION TRUST	0	0	*	*	0	0	0
RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	27	31	44	38	60	54	40
RGD	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	0	0	0	*	0	0	*
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	51	80	111	117	108	148	183
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	0	0	*	6	13	20	*
RJ2	LEWISHAM AND GREENWICH NHS TRUST	16	14	16	11	20	48	46
RY5	LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	0	0	*	*	*	*	*
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	0	0	0	*	*	*	*
RY1	LIVERPOOL COMMUNITY HEALTH NHS TRUST	0	0	*	*	0	0	0
RBQ	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	*	*	0	*	17	7	*
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	*	*	*	0	0	0
R1K	LONDON NORTH WEST HEALTHCARE NHS TRUST	0	0	0	0	0	104	112

Provider Trust		2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
RC9	LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	37	30	40	39	40	52	46
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	15	22	32	37	30	30	31
RPA	MEDWAY NHS FOUNDATION TRUST	32	23	24	17	41	36	44
RW4	MERSEY CARE NHS FOUNDATION TRUST	*	0	0	0	0	*	*
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	7	7	11	7	15	7	18
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	7	12	13	12	16	15	21
RJD-X	MID STAFFORDSHIRE NHS FOUNDATION TRUST	13	19	24	22	15	12	0
RXF-X	MID YORKSHIRE HOSPITALS NHS TRUST	20	31	29	37	32	74	49
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	21	26	22	24	25	31	25
RNH	NEWHAM UNIVERSITY HOSPITAL NHS TRUST	13	23	28	0	0	0	0
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	20	31	38	35	54	82	61
RY3	NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST	0	0	6	*	*	7	7
RVJ	NORTH BRISTOL NHS TRUST	42	0	0	0	0	0	0
RVJ-X	NORTH BRISTOL NHS TRUST	0	28	46	34	53	43	39
RNL	NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	14	9	16	29	22	11	33
RAT	NORTH EAST LONDON NHS FOUNDATION TRUST	0	0	0	*	*	*	*
RN5T1	NORTH HAMPSHIRE HOSPITALS NHS TRUST TREATMENT CENTRE	*	0	*	0	0	0	0
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	18	17	22	30	17	35	27
RLY	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	*	*	0	0	*	*	*
RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	20	48	27	31	31	67	69
RV8	NORTH WEST LONDON HOSPITALS NHS TRUST	29	33	94	66	86	0	0
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	23	13	31	23	30	24	49
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	*	9	16	14	20	22	16
RJL-X	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	*	13	9	15	22	12	16
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	38	67	45	49	73	43	68
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	73	87	80	100	98	146	160
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	*	*	*	*	*	*	0
RBF-X	NUFFIELD ORTHOPAEDIC CENTRE NHS TRUST	*	*	0	0	0	0	0
RNU	OXFORD HEALTH NHS FOUNDATION TRUST	0	0	*	*	*	*	6
RTH	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	27	56	62	61	89	80	105
RPG	OXLEAS NHS FOUNDATION TRUST	0	*	*	*	*	*	*
RGM	PAPWORTH HOSPITAL NHS FOUNDATION TRUST	*	*	*	*	*	19	9
RW6	PENNINE ACUTE HOSPITALS NHS TRUST	40	55	40	33	73	100	123

Provider Trust		2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
RT2	PENNINE CARE NHS FOUNDATION TRUST	0	0	*	*	0	*	0
RGN	PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST	18	12	15	23	19	14	29
RK9	PLYMOUTH HOSPITALS NHS TRUST	87	97	95	105	86	76	92
RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	14	18	37	44	32	31	22
RHU	PORTSMOUTH HOSPITALS NHS TRUST	64	63	70	57	73	92	116
RPC	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	0	*	0	*	0	0	*
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	29	34	23	20	19	34	26
RT3	ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	*	*	10	6	12	7	10
REF-X	ROYAL CORNWALL HOSPITALS NHS TRUST	51	55	76	83	76	103	108
RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	37	41	31	19	22	28	37
RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	24	37	87	128	73	69	104
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	30	48	58	46	69	44	54
RBB	ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST	0	*	*	*	0	0	0
RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	*	0	*	7	*	*	*
RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	9	14	26	8	14	19	26
RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	26	60	38	47	38	50	60
RM3	SALFORD ROYAL NHS FOUNDATION TRUST	40	53	71	67	81	76	101
RNZ	SALISBURY NHS FOUNDATION TRUST	19	23	17	17	19	26	22
RXK-X	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	27	46	50	42	50	60	62
RCC	SCARBOROUGH AND NORTH EAST YORKSHIRE HEALTH CARE NHS TRUST	55	33	14	0	0	0	0
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	*	*	*	*	*	*	6
RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	29	34	35	42	56	82	96
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	19	26	24	27	20	43	46
RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	11	25	33	35	40	47	45
R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	0	0	*	*	*	*	*
R1C	SOLENT NHS TRUST	0	0	8	12	*	*	*
RH5	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	0	0	*	80	32	17	54
RWN	SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	*	*	0	0	0	0	*
RYQ	SOUTH LONDON HEALTHCARE NHS TRUST	38	66	79	56	14	0	0
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	22	37	32	23	26	38	46
RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	23	23	18	19	17	15	27
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	12	15	15	18	14	10	12
RQY	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	0	*	0	*	*	*	0

Provider Trust		2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	0	*	*	*	15	8	8
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	24	34	22	40	38	35	23
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	*	*	6	*	*	11	10
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	6	16	13	12	10	24	8
RJ7	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	28	54	46	44	63	61	33
RBN	ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	17	29	44	39	44	74	74
R1E	STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST	0	0	*	*	*	*	8
RWJ	STOCKPORT NHS FOUNDATION TRUST	20	21	28	32	25	32	37
RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	0	0	0	*	0	0	0
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	14	13	31	28	32	26	28
RDR	SUSSEX COMMUNITY NHS FOUNDATION TRUST	0	*	*	*	0	0	0
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	0	*	0	*	*	*	*
RMP	TAMESIDE HOSPITAL NHS FOUNDATION TRUST	10	11	21	6	16	39	34
RBA	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	25	24	19	32	33	43	73
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	0	0	0	*	0	*	0
RBV	THE CHRISTIE NHS FOUNDATION TRUST	9	44	79	66	217	259	121
REN	THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	*	*	0	0	0	0	*
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	47	23	33	32	40	25	56
RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	20	18	23	21	13	13	25
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	75	61	85	85	94	101	102
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	11	33	51	30	22	44	25
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	9	6	*	7	*	9	31
RL1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	0	*	*	0	*	*	*
RFR	THE ROTHERHAM NHS FOUNDATION TRUST	8	9	11	*	8	13	21
RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	28	14	25	22	27	19	30
RPY	THE ROYAL MARSDEN NHS FOUNDATION TRUST	*	9	6	9	10	*	*
RRJ	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	*	0	*	0	0	0	*
RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	12	47	46	44	59	54	65
RET	THE WALTON CENTRE NHS FOUNDATION TRUST	0	0	*	6	*	0	0
RKE	THE WHITTINGTON HOSPITAL NHS TRUST	9	17	10	29	17	18	30

Provider Trust		2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
RA9	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	18	17	23	30	33	36	65
R1G	TORBAY AND SOUTHERN DEVON HEALTH AND CARE NHS TRUST	0	0	0	8	7	10	0
RM4	TRAFFORD HEALTHCARE NHS TRUST	*	11	14	0	0	0	0
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	30	29	23	18	22	28	36
RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	29	49	31	71	63	78	34
RM2	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	17	27	32	40	14	19	19
RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	68	83	82	58	112	106	95
RRK-X	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	25	51	34	74	73	58	59
RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	37	26	49	36	44	63	67
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	34	29	58	41	77	109	91
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	84	85	83	66	108	128	122
RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	28	24	22	23	24	33	53
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	48	34	49	89	49	42	74
RBK	WALSALL HEALTHCARE NHS TRUST	11	22	64	46	42	58	88
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	17	32	27	38	28	33	40
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	32	23	26	36	39	34	51
RFW	WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	13	6	7	13	14	23	0
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	46	36	49	42	43	43	38
RYR-X	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	56	63	61	53	79	97	131
RA3	WESTON AREA HEALTH NHS TRUST	6	*	11	*	11	8	7
RGC	WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST	14	17	20	0	0	0	0
RN1	WINCHESTER AND EASTLEIGH HEALTHCARE NHS TRUST	0	0	10	0	0	0	0
RN1-X	WINCHESTER AND EASTLEIGH HEALTHCARE NHS TRUST	17	21	0	0	0	0	0
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	21	34	45	91	707	728	586
RWP-X	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	15	27	28	34	34	21	33
R1A	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	0	0	*	*	7	*	*
RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	18	10	14	23	27	65	69
RLQ	WYE VALLEY NHS TRUST	7	*	9	8	7	14	14
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	44	47	89	102	104	95	79
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	16	7	17	55	55	63	58

Source: Hospital Episode Statistics (HES), NHS Digital

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