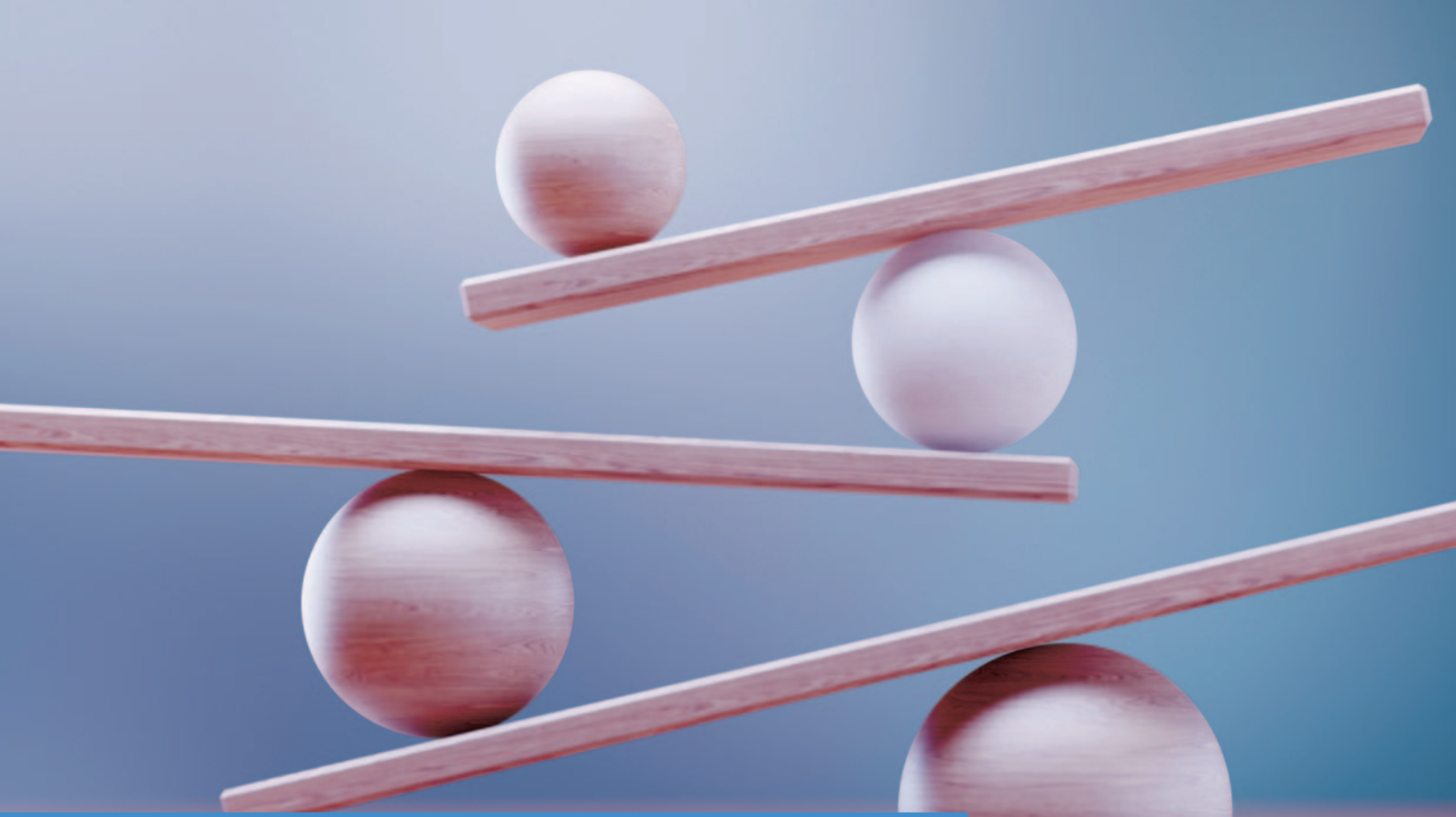

Balancing Necessity and Sustainability

Perspectives on NHS England's Commissioning Statement for Home Parenteral Nutrition



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In England, the prevalence of patients receiving home parenteral support (HPS) is approximately 50 per million population across all age groups.[1] This equates to around 2,500 individuals currently accessing HPS services, with roughly 30% of these patients receiving support on a long-term basis (five years or more).

This article explores the perspectives of two leading healthcare professionals in the field of intestinal failure and clinical nutrition, who offer informed and contrasting insights into NHS England's Commissioning Statement for Home Parenteral Nutrition (HPN).[1] Their views help illuminate the challenges and implications of aligning national policy with clinical practice.

About

Kirstine Farrer is a Consultant Dietitian specialising in intestinal failure, short bowel syndrome and HPS on the national unit at Northern Care Alliance NHS Foundation Trust. As well as extensive NHS management and clinical experience, Kirstine is very active at a national level with her roles, including being a member of NHS England (NHSE) Clinical Management Advisory Group for HPN, British Intestinal Failure Alliance Deputy Chair – a Special Interest Group of the British Association for Enteral and Parenteral Nutrition – and a parenteral nutrition Committee Member for the British Dietetic Association's Parenteral and Enteral Nutrition Group.

Professor Simon Lal is a Professor of Gastroenterology at the University of Manchester and has been the lead of a UK National Intestinal Failure Reference centre since 2012 with clinical and academic interests in clinical nutrition, intestinal failure and inflammatory bowel disease. He is the co-chair of the European Society for Clinical Nutrition and Metabolism (ESPEN) Home Artificial Nutrition Special Interest Group, a member of the Education Committee of ESPEN and Nutrition Lead of the Scientific Committee of United European Gastroenterology. Professor Lal has published more than 220 peer-reviewed articles in the international literature as well as a number of book chapters on subjects related to intestinal failure.

Views of the Commissioning Statement

The NHSE Commissioning Statement is a strategic and pragmatic response to the increasing demand for HPS and the limited aseptic pharmacy capacity to manufacture compounded parenteral support (PS) in England. It promotes the use of ready-made multi-chamber bags (MCBs) or a hybrid approach (a combination of MCB and/or fluids and compounded bags across the week) reserving compounded PS for paediatric or adult patients with complex fluid, electrolyte or nutritional needs. The introduction of a NHSE Clinical Advice and Management Group (CAMG) ensures a single point of entry for clinical teams requiring a supplemented MCB regimen; a hybrid regimen; or a full compounded regimen for their patient. This ensures oversight of patient activity, equitable access, cost-effectiveness and sustainability of the HPS services in England by reserving compounded HPS for those patients who really need it.

Interpretation into practice

The statement and introduction of the NHSE CAMG meeting has forced a change in practice, and it has raised awareness of using the licensed, ready-made MCB product as a first line approach for patients requiring HPS. Patients should receive licensed treatments wherever possible; if not, there should be a detailed risk assessment to justify why the clinical team do not believe this is suitable. Thus, MCBs should be selected over non-licensed compounded HPS regimens, where possible.

Furthermore, the demand for compounded PS may exceed the capacity of the aseptic pharmacy service so compounding must be prioritised for those paediatric and adult patients with the greatest clinical need. With the manufacture of compounded PS, there is also an associated risk of contamination and a requirement for resource intensive aseptic conditions, and manufacture is therefore limited for safety reasons to a small number of specialised approved providers who are on the NHSE commercial framework. This capacity can readily become exhausted if demand exceeds supply so the use of MCBs, wherever possible, alleviates pressure on aseptic pharmacy services and ensures vulnerable patients have continued access to the treatment they need.

The initial assessment of all new HPS patients includes evaluation for MCB suitability. MCBs are considered first-line licensed medication, unless there are clinical contraindications.

Compounded HPS is reserved for patients with complex metabolic needs, electrolyte and/or micronutrient requirements that cannot be met by MCBs.

This has led to standardisation of assessment protocols and closer collaboration between dietitians, pharmacists, nurses and physicians.

Patient assessment for MCB suitability

When the team have identified that the patient requires HPS the patient should be initially considered as a potential candidate for a MCB regimen. The assessment includes:

- Nutritional and fluid requirements: This includes volume, energy, protein and electrolytes.
- Stability of clinical condition: The patient's clinical condition must be stable to allow variation in PS prescription during the week.
- Micronutrient needs: It is important to determine whether the individual can have oral micronutrients or whether they require intravenous micronutrients. If the latter, how often do they need intravenous micronutrients through the week. A person's ability to have oral micronutrients is determined by the amount of functional intestine they have.
- Infusion schedule and central venous catheter access: It is important to determine whether the patient can be trained to self-administer their HPS or requires the homecare company nurse. Multiple bag infusions that may be required using a combination of intravenous fluids/MCBs/micronutrients can often be more easily administered by nurses, but it is, of course, important to maintain a person's autonomy in administering their HPS wherever feasible.
- Tolerance and previous HPS history: It is important to know whether the patient has tolerated MCBs in the past, including when they were on holiday, and whether they managed the infusions.

If MCBs meet the patient's needs, they are initiated. If not, a justification for a hybrid regimen or compounded PN is recorded.

Changes in practice & managing change

Yes, practice has changed significantly in the last 5-6 years for the teams and patients. Before the change, nearly 100% of our patients with new-onset chronic intestinal failure were prescribed compounded HPS, now less than 40% receive compounded HPS and this is a similar picture nationally.

This is because there has been a considerable shift in mindset of clinical teams from defaulting to compounded PS to use MCBs as a first line treatment.

Education and training have been important for all members of the nutrition support team on MCB formulations, stability and administration, especially considering multiple infusions.

Patient engagement has been supported in the UK by PINNT (a support group for people receiving artificial nutrition) at a national level, so the patient does not feel they are on a sub optimal regimen. This change in clinical practice has resulted in more structured conversations about the rationale for MCBs with patients. MCBs and IVFs do not require to be kept in the fridge, which reduces the financial burden on patients/carers and is also better for the environment. If the patient is self-caring, then MCBs can promote more independence to venture on holiday without the worry of disrupting the aseptic cold chain.

However, it has not been without challenge; some clinicians were initially reluctant due to concerns about adequacy or flexibility of MCBs. Patients can be very anxious about change, especially if previously stable on compounded PS, hence we have not swapped many existing patients to this model. We have only used this with new patients prospectively. By clearly communicating about safety, efficacy and close monitoring, there has change in practice whilst building trust with patients.

Patients already on compounded PN

All patients should have their HPS regimen and their contingency regimen (i.e. an emergency non-compounded regimen required at the time of a compounded HPS supply crisis) reviewed at each clinic appointment. As the patient's clinical, fluid and electrolyte needs change (e.g. following surgery or during treatment with entero-hormonal therapy), this may be an opportunity to discuss incorporating MCBs to their regimen.

There are 4 categories which need to be considered – clinical, psychological, logistical, and systemic categories:

1. **Clinical barriers**
   - Complex nutritional needs: Patients with highly individualised electrolyte, fluid or micronutrient requirements may not be adequately supported by standard MCB formulations.
   - Fluid restrictions: MCBs often come in fixed volumes, which may not suit patients with cardiac or renal comorbidities or patients with very high-volume requirements.
   - Metabolic instability: Patients with frequent changes in nutritional status or requiring acetate may require compounded regimens.

- **Allergies or intolerances:** Some patients may react to components in MCBs (e.g. lipid emulsions). Be aware some lipids contain soya or fish oils, so check for allergies before swapping the patient over to this bag. All lipid containing MCBs/compounded bags contain trace amounts of vitamin K through the presence of vitamin K in soya oil; this needs to be considered in those with vitamin K allergy.

2. Psychological and patient-centred barriers

By reviewing HPS regimens routinely and proactively with the patient it helps highlight the benefits for the whole patient population (e.g. use of the licensed medication [MCB]); more consistent supply chain; reduced infection risk and convenience. It is important to acknowledge concerns: *"We understand this is a big change, and we'll support you every step."*

- **Fear of change:** Patients stable on compounded HPS may fear destabilisation or complications.
- **Perceived loss of control:** Some patients feel more secure with one compounded HPS regimen It is important to stress all HPS regimens are tailored to the individual and there are many factors that clinicians consider.
- **Mistrust or misunderstanding:** Patients may not understand the rationale for switching and may interpret it as cost-cutting at the expense of care.
- **Attachment to routine:** Long-term HPS users often develop strong routines and may resist changes that disrupt their sense of normalcy.

3. Healthcare professional (HCP) barriers

- **Clinical inertia:** HCPs may be reluctant to change a regimen that is working well.
- **Lack of familiarity:** Some clinicians may not be fully confident in the nutritional adequacy or safety of MCBs. It can be challenging to try the MCB regimen prior to discharge home due to pharmacy constraints and contracts.
- **Time constraints:** Reassessing patients and managing the switch requires time, coordination, and monitoring.

4. Logistical & systemic barriers

- **Supply chain issues:** Availability of specific MCB formulations may vary.
- **Prescribing systems:** Electronic prescribing platforms may not be optimised for MCBs.
- **Training needs:** Both patients and carers may need retraining on new administration techniques or schedules.
- **Monitoring burden:** Initial switch may require more frequent blood tests and follow-up appointments.

Overcoming barriers – practical tips

- **Education:** Provide clear, evidence-based explanations to both patients and clinicians.
- **Trial periods:** Offer a monitored trial of MCBs with the option to revert if issues arise.
- **Shared decision-making:** Involve patients in the decision and respect their preferences.
- **Support materials:** Use leaflets, videos, or peer support to ease the transition.
- **Multidisciplinary approach:** Involve dietitians, pharmacists, nurses and physicians in planning and follow-up.

Outputs from the Commissioning Statement

Positives:

- Safeguarded the supply of HPS to those who need it, by protecting and preserving national aseptic pharmacy capacity is a vital lifeline for our patients.
- The CAMG has improved resource allocation in a timely manner and now Trusts can choose which homecare company once their patient has been approved by NHSE.
- Streamlined logistics for HPS provision in England.

Negatives:

- Initial resistance from some clinicians and patients.

When is a patient not suitable for MCBs?

Patients may not be suitable if they have:

- Highly individualised fluid or electrolyte needs (e.g. a child under 40 kg)
- Severe fluid restrictions whilst needing to meet full nutritional needs
- Micronutrient deficiencies not covered by MCBs or a supplemented HPS regimen.
- Unstable metabolic conditions (e.g. on haemodialysis, cardiac failure, inherited metabolic disorders)
- Allergies to individual MCB components.
- In such cases, compounded HPS remains essential. Preserving supply means that these patients receive the compounded HPS they require.

Conclusion

The new commissioning approach helps to preserve vital resources for patients with the most complex needs while enhancing the resilience and sustainability of HPS services in England. It represents a carefully balanced policy that integrates clinical judgement, patient-centred care and national strategy – ensuring that those who rely on HPS continue to receive high-quality and tailored support.

References: **1.** NHS England (2023). Commissioning Statement: Parenteral nutrition for the treatment of adults and children with Type 2 and Type 3 intestinal failure requiring home parenteral support. Accessed online: www.england.nhs.uk/wp-content/uploads/2023/10/2267-hpn-commissioning-statement.pdf (Aug 2025).