



Achieving Savings from High Cost Drugs

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Author	Clare Howard, National Director, QIPP Medicines Use and Procurement Workstream
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Contact Details	Clare Howard National Lead, QIPP Medicines Use and Procurement Skipton House London SE1 6LH
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Achieving Savings from High Cost Drugs

Excluded from the PbR Tariff

Prepared by

Clare Howard

National Lead

QIPP Medicines Use and Procurement Programme

Introduction

1. This paper sets out how commissioners and providers of NHS services can work together to achieve significant savings in the use of high cost drugs which are excluded from the Payment by Results (PbR) tariff. It is intended to support commissioners and providers in delivering their NHS Constitution obligations and in their introduction of the Compliance Regime for NICE Technology Appraisals.

Background

2. The Payment by Results Tariff maintains a list of high cost medicines that are excluded from the scope of tariff. For excluded medicines, commissioners and providers agree local prices and local arrangements for monitoring activity. Because acquisition costs may be reimbursed by commissioners, there may be little incentive for a provider to maximise the cost-effectiveness of these treatments, particularly where providers have to make decisions on prioritisation of their resources or if improvements in cost-effectiveness require the commitment of additional resources.

3. In his report *Homecare Medicines: Towards a Vision for the Future* which was commissioned by the Department of Health, Mark Hackett CEO University Hospitals Southampton, recommended that commissioners should ensure that as part of national or regional procurement arrangements for medicines, there are clear, up-front agreements on the share of financial savings with both commissioners and providers.¹

4. The majority of medicines supplied via Home Care are excluded from the PbR Tariff. Therefore, this framework is pertinent to ensuring maximum efficiencies are realised from the Home Care medicines bill, which is now over £1 billion per year.

5. Of course, many PbR excluded medicines are supplied via more traditional routes and this framework applies to them as well.

Why Use Incentive Schemes?

6. Incentive schemes have worked well in primary care prescribing and therefore it is logical to use a similar approach to produce efficiencies in drugs budgets in other care settings where prescribing is taking place. Incentivising providers to look at these high cost drugs and move to less expensive alternatives or more effective procurement strategies benefits the whole NHS. This framework will help CCGs to ensure that efficiencies are delivered within the 2013/14 financial year.

7. Health economies may not make the best use of their resources and lose the opportunity to improve their quality of care unless they have agreements in place to ensure that providers actively seek the most clinically and cost effective medicines that are not included in the PbR tariff. The NHS may therefore be paying for

¹ Home Care Medicines - Towards a Vision for the Future. Mark Hackett CEO UHS NHS FT

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- more expensive treatments where equally effective but cheaper alternatives are available.
- medicines that have not been procured in the most cost effective way.

Scope for Savings

8. Currently, it is estimated that approximately 60% of the cost of medicines used by providers of secondary and tertiary care may be accounted for by medicines which fall outside the scope of the PbR tariff. In England, the spend on medicines in hospitals in 2011 was around £4.3 billion.² Therefore, we can reasonably assume that the cost of PbR excluded drugs in England could be up to £2.6 billion per year. Some Trusts, especially tertiary care centres report that their PbR excluded drugs account for significantly more than 60% of their total drug spend.

Criteria for local schemes for PbR excluded drugs and gain sharing.

9. Many areas of the county already operate “gain sharing”. Local schemes that are already successfully operational and delivering savings have the following criteria in common: -

- Simple and not overly bureaucratic.
- Board level engagement and support in both the commissioning and providing organisations – not just seen as the domain of senior pharmacists.
- Both commissioner and provider aim to see the wider picture of efficiencies
- Good working relations between commissioner and provider and pharmacy and finance departments.
- Pharmacy departments in provider organisations are properly resourced to do deliver any changes.
- Using simple data to set baselines eg cost per unit over the previous two years.
- Joining up “gain sharing” with regional procurement and Home Care initiatives to maximise the efficiencies that can be gained.
- Annual review to reflect changes in workload once new initiatives are bedded in, document progress and to ensure that new priority areas are identified.
- Flexibility to be adapted on a scheme by scheme basis to ensure a “fair” share of savings.

² Hospital Prescribing England 2011: NHS Information Centre November 2012

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- Open and transparent monitoring arrangements with absolute agreement on the baseline, data source and KPIs.
10. Pitfalls to avoid include: - .
- Entrenched positions on the detail of baselines or incentives.
 - Adversarial relationships may mean that gain sharing schemes are not adopted and therefore the overall spend is not managed.
 - Agreeing to baseline pricing data is problematic and protracted discussions may prevent any savings from being realised

Resourcing Incentive Schemes

11. A significant proportion of the work to release savings will fall to pharmacy teams. Providers should therefore consider that a proportion of the savings generated should be used to resource pharmacy teams to undertake this role. The detailed arrangements are a matter for providers but they will be aware of the effect insufficient capacity within pharmacy departments will have on their ability to contribute effectively to the development and management of gain sharing schemes.

Getting Started (See also worked examples in Annex)

12. At the beginning, experience shows that the best way of making progress is to concentrate on the priority areas agreed between commissioner and provider, for example, focussing on QIPP medicines plans or areas identified as maximising value for money and/or addressing key medication safety issues. If agreeing areas to pursue is problematic, start simply with one therapeutic area that may be less controversial. E.g. HIV medicines. Agreed schemes can be adopted in a variety of localities with minor alterations around process – there is no need to re-negotiate at length in each locality. Success in year one enables providers and commissioners to build in future years. The Annex gives some examples of local work.

It is anticipated that a significant proportion of the work to release savings will fall to pharmacy teams. To reflect this, Providers should consider that a proportion of the payment should be used to resource Pharmacy teams properly. Obviously, the details of such arrangements are a matter for the Provider. However, Providers must recognise the impact of insufficient capacity within Pharmacy Departments.

Trust boards should be aware of the limitations to the whole health economy of not investing in pharmacy resource to deliver change year on year. The relationship between Pharmacy and Finance is critical.

The future – post April 2013

13. The arrangements set out in this paper can continue to deliver savings and, as tried and tested mechanisms, will be useful for providers and commissioners as they get to grips with their roles post April 2013. Some commissioners will be very familiar with the operation of prescribing incentive schemes in general practice whilst others will be familiar with the way that PbR excluded drugs are funded. It will be important for commissioners and providers to pool knowledge and continue to work together.

Significant contributions from:

Julia Wright, Commissioning Pharmacist Hampshire PCT.

Gaye Lewington, Commissioning Pharmacist West Kent PCT

Dennis Lauder, Chief Pharmacist Heatherwood and Wexham Park Hospital and Chair Pharmaceutical Market Support Group.

Kim Perry, Assistant Director of Finance University Hospitals Southampton.

Andrew Bertram, Director of Finance Harrogate and District NHS Foundation Trust

Kim Gay, Director of Financial Management The Leeds Teaching Hospitals NHS Trust

ANNEX

EXAMPLES OF CURRENT SUCCESSFUL SCHEMES

NHS South Central

1. In 2010, South Central Chief Executives acknowledged the issues concerned with PbR excluded drug costs and asked that the Medicines Use and Procurement QIPP workstream devise a framework to support primary and secondary care Trusts working in collaboration to address this and realise the efficiencies.
2. Workshops and teleconferences with both commissioning and provider organisations revealed that there was significant variation in progress on this issue and whilst some health economies had worked hard to reach agreement, almost no health economy in South Central had completely agreed a process for PbR excluded drugs that both parties felt was fair and that was delivering efficiencies.
3. A framework was developed and ratified in early 2011 and all health economies in the region are now reporting some degree of gain sharing.

NHS Midlands and East

4. The region has recently set out recommendations for Trusts and Commissioners to share gains. They advised that if successfully implemented, the agreements for sharing savings between Commissioner and Provider would act as a catalyst to the aforementioned delivery, which could then kick-start the realisation of significant cost efficiency benefits (potentially tens-of-millions of pounds) against the QIPP prescribing agenda.

Practical Operation

5. One area's experience was that the framework not only provided guidance for Providers and Commissioners to start discussions which explored saving schemes on high cost medicines, but also afforded them the freedom and flexibility to negotiate and agree schemes that could be delivered, captured and reported in their individual settings. There were 3 methodologies employed between providers and commissioners in 11/12:-
 - DGH 1-50:50 split of savings reported on a small number of agreed specific lines.
 - DGH 2-50:50 risk share for overspend and 75:25 (Provider : PCT) risk share for underspend. Applied across all cancer and PbR excluded drugs - not to specific lines.
 - University Teaching Hospital-Variable share over variable timeframes, 70:30, 60:40, 50:50 (Provider : PCT) depending on scheme for a small number of specifically agreed lines. For some schemes, a higher share in Y1 for the provider was agreed to reflect the amount of additional work needed to set it up.