DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Derbyshire CCGs principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national tariff prices

Background

Historically, Commissioners have worked closely with their Acute Providers endeavouring to procure high cost drugs at the best value for money. Whilst this may be achieved simply through a reduction in prices, some schemes may require additional resources from the provider organisations in order to achieve the greater efficiencies for the local health economy. High cost drugs excluded from tariff are all reimbursed by commissioners and therefore 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.

A paper has been produced by the NHS England Specialised Commissioning Medicines Optimisation CRG (Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national tariff prices[1] – January 2014) which aims at establishing some principles for organisations working collaboratively to achieve both better outcomes for patients and greater efficiencies in the use of medicines which are not reimbursed via national prices set out in the National Tariff. It describes how NHS England will incentivise provider trusts to ensure maximum value for money from medicines excluded from National Tariff but also suggests that CCGs (who also fund these medicines) could adopt the same principles.

Criteria for local schemes for high cost drugs that are not reimbursed through national prices set out in the National Tariff

The nationally agreed work in 2012 outlined a number of criteria for successful 'gain share' agreements[2]. Building on these principles, NHS England supports incentive arrangements that aim for the following[1]:

- That processes developed to improve efficiencies in the cost effective use of medicines should maintain, if not improve, the quality of patient experience.
- Be simple and not overly bureaucratic.
- Result in reduced medicines wastage.
- Have senior (e.g. Director) level engagement and support in both the commissioning and providing organisations – not just seen as the domain of senior pharmacists.
- Have relevant clinicians engaged in the process at the earliest opportunity.
- Both commissioner and provider aim to see the wider picture of efficiencies.
- Good working relations between commissioner and provider, pharmacy and finance departments.
- Any efficiencies and incentives appropriately reflect the work that pharmacy departments have to do in order to maximise the efficiencies available.

- Use simple data to set baselines e.g. cost per unit over the previous two years.
- Join up “gain sharing” with regional procurement, Home Care and QIPP 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 ensure that new priority areas are identified.
- Flexibility to be adapted on a scheme by scheme basis to ensure a “fair” gain for Providers.
- Open and transparent monitoring arrangements with absolute agreement on the baseline, data source and Key Performance Indicators (KPIs).
- Schemes should be developed in consultation with local CCGs to ensure there are no unintended consequences for primary care or unplanned impact on CCG commissioning arrangements with the Trust(s) in question.
- These arrangements do **not** apply to medicines funded via the National Cancer Drugs Fund.

Potential areas for greater efficiency

Areas where changes in secondary care provider behaviours and/or activity which can produce significant efficiencies for the NHS (and hence worth incentivising) could include:

- Medicines use – e.g. prescribing a more cost effective alternative.
- Medicines procurement – e.g. entering into collaborative procurement arrangements for medicines.
- Medicines manufacture/preparation – e.g. moving to more effective operating strategies such as vial sharing or aseptic unit patient cohorting.
- Medicines supply – e.g. moving to alternative delivery arrangements, such as Homecare or outsourced outpatient dispensing.
- Medicines wastage - e.g. strategies to reduce injectable chemotherapy wastage.

Resourcing incentive schemes

A significant proportion of the work to release savings will fall to provider pharmacy teams. It would therefore seem appropriate that these additional costs and time incurred (pharmacy teams, infrastructure and information technology) to undertake this role should be paid to the provider before agreement of the apportionment of any saving. The detailed arrangements are a matter for providers but they will be aware of the effect that insufficient capacity within pharmacy departments will have on their ability to contribute effectively to the development and management of any schemes to deliver efficiencies.

CCGs additional criteria

In addition to the criteria out above, the following principles should apply to any CCG approved incentive arrangements:

Trusts and commissioners should work together to identify schemes that will deliver efficiencies. Savings should be fully transparent and agreement reached before the scheme is undertaken on how the benefits will be shared.

- Where a scheme creates additional administrative burden (usually to the pharmacy service) and is not directly linked to activity and hence a tariff payment e.g. provision on home delivery services, the commissioner and Trust should agree how any efficiency can be used to fund additional resource e.g. a pharmacy technician.
- Any efficiencies made on high cost medicines, after adjustment for the administrative burden, will be shared between Provider and Commissioner organisations and utilised in line with the relevant organisation's transformation strategies.
- The funds released may not necessarily be reinvested in the specialty/clinical area from which they were realised.
- Schemes should not influence changes in clinical practice which would be detrimental to the level of care or the quality of outcome a patient receives.
- All approved schemes should be formally 'signed off' by the director of finance and prescribing for both provider and commissioner.
- All approved schemes should include a start and stop date to ensure all parties are clear about the arrangement. Arrangements can be rolled over after the stop date but that must be formally agreed. Some schemes may have a defined timescale whilst other may continue indefinitely. Those that continue will be subject to an annual review.
- Schemes must **not** be linked to medicines that are part of clinical trials.
- The timescales for any agreement should be in line with the normal contract schedule and should entail: (a) initial discussion; (b) negotiation; (c) agreement and (d) implementation.

Recommendations:

CCGs in Derbyshire will work collaboratively with local Acute Providers in order to develop proposals designed for sharing the benefits associated with more efficient use of high cost drugs using the principles set out in this paper above.
Lead CCG commissioners will develop specific arrangements with their respective Trusts to include principles for different types of proposal.

References:

[1]*Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices January 2014 (Gateway reference number: 01014)*

[2]*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127167/high-cost-drugs.pdf.pdf (Gateway reference number: 18170)*