# GE3: Hospital Medicines Optimisation (updated for April 2018)

|  |  |
| --- | --- |
| **Scheme Code and Full Name:**  | ***GE3 Hospital Pharmacy Transformation and Medicines Optimisation*** |
| **Section A. SUMMARY of SCHEME**  |
| QIPP Reference | *[QIPP reference if any: Add Locally]* |
| Duration | April 2017 to March 2019 |
| **Problem to be addressed:**Optimising the use and management of medicines is a significant and realisable opportunity for the NHS. The Carter Review has highlighted that unwarranted variation in use and management of medicines costs the NHS at least £0.8billion per year that could be re-invested to support sustainable service delivery. This CQUIN has been designed to support Trusts and commissioners to realise this benefit through a series of modules that improve productivity and performance related to medicines. The expectation is that the targets and metrics will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice and effective remedial interventions.  |
| **Change sought:**This CQUIN scheme aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services. The following priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office, namely:* Faster adoption of best value medicines with a particular focus on the uptake of best value generics, biologics and CMU frameworks as they become available
* Significantly improved drugs data quality to include dm+d code and all other mandatory fields in the drugs MDS and outcome registries such as SACT, as well as to meet the requirements of the ePharmacy and Define agendas
* The consistent application of lowest cost dispensing channels
* Compliance with policy/ consensus guidelines to reduce variation and waste.
 |
| **Section B. CONTRACT SPECIFIC INFORMATION** *(for guidance on local completion, see corresponding boxes in sections C below)* |
| **B1.Provider** *(see Section C1 for applicability rules)* | *[Insert name of provider]* |
| **B2.Implementation Timing.** What was or will be the first Year of Scheme for this provider, & how many years are covered by this contract? | 2017/18 Twoyears |
| **B3.Scheme Target Payment** *(see Section C3 for rules to determine target payment)* | Full compliance with this CQUIN scheme should achieve payment of: *[State Financial value following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]*Target Value:  *[Add locally ££s]* |
| **B4. Payment Triggers.**The Triggers and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.Relevant provider-specific information is set out in this table. *[For Local Completion, or deletion, as required.]*

|  |  |  |
| --- | --- | --- |
| **Provider specific triggers** | **2017/18** | **2018/19** |
| **Trigger 1:****Baseline** |  |  |
| **Trigger 1:****Stretch level** |  |  |
| **Trigger 2:****Baseline** |  |  |
| **Trigger 2 stretch** |  |  |
| **Trigger 3** |  |  |
|  | *[Add rows if required.}* |  |

 |
| **B5. Information Requirements** |
| Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5. |
| Final indicator reporting date for each year. | Month 12 Contract Flex reporting date as per contract. *[Vary if necessary.]* |
| **B6. In Year Payment Phasing & Profiling** |
| Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.  |
| **Section C. SCHEME SPECIFICATION GUIDE** |
| **C1. Applicable Providers** |
| ***Nature of Adoption Ambition:*** Providers with significant expenditure on tariff-excluded high cost drugs. |
| **C2. Setting Scheme Duration and Exit Route** |
| This is a 2-year scheme. The year 1 payment triggers are focussed on transitioning to new arrangements for the use and management of medicines. The year 2 payment triggers are focussed on further improvement goals.However, the CQUIN for each hospital provider will reflect the development needs of that provider, which will be reflected in the choice of modules and transitional and / or improvement goals. | Most modules are expected to be implemented within 12 months and further improvement goals achieved in the following 12 months.The hospital pharmacy transformation programme will be fully implemented by 2020. This CQUIN and contract covers the first 2 years of the programme and is designed to support hospital providers to carry out the required change management in the first year and embed the changes in second.  |
| **C3. Calculating the Target Payment for a Provider**  |
| The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm: **<1% of the Provider’s spending upon high cost drugs>**If a hospital has anticipated spending on high cost drugs of £25m, this CQUIN scheme would attract a target payment of £250,000.Year One: 1% of the 2017/18 contract value for tariff-excluded high cost drugsYear Two: 1% of the 2018/19 contract value for tariff-excluded high cost drugs**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**  |
| **C4. Payment Triggers and Partial Achievement Rules** |
| **Payment Triggers**The interventions or achievements required for payment under this CQUIN scheme are as follows:

|  |  |  |
| --- | --- | --- |
| **Descriptions** | **2017/18** | **2018/19** |
| **Trigger 1:****Faster adoption of prioritised best value medicines and treatment regimens as they become available**  | 1a) Adoption of best value generic/ biologic products in 90% of new patients within one quarter of guidance being made available. 1b) Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available (except if standard treatment course is < 6 months).1c) N/A | 1a) Adoption of best value generic/ biologic products in 90% new patients within one quarter of guidance being made available. 1b) Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available (except if standard treatment course is < 6 months).1c) Reviewing and switching of applicable existing patients to appropriate regimen treatments in line with NHS England agreed policy/ consensus guidelines, e.g. HIV, MS, (except if standard treatment course is < 6 months).Targets for switching applicable patients will be agreed locally as and when the policy/guidelines are published and taking into account current guidelines where there is further opportunity for optimising use of medicines. |
| **Trigger 2****Improving drugs MDS data quality** | Improving drugs MDS data quality to include dm+d as drug code in line with ISB 0052 by June 2017 or in line with agreed pharmacy system upgrade as well as all other mandatory fields.All hospitals submit HCD data in agreed MDS format fully, accurately populated on a monthly basis and bottom line matches value for drugs on ACM. | N/A  |
| **Trigger 3****Cost effective dispensing routes** | Increase use of cost effective dispensing routes for outpatient medicines: - Implementation of agreed transition plan for increasing use of cost effective dispensing routes for outpatient medicines (plan to be developed by drug category to take into account patient population).Transition to agreed cost per item reimbursement approach as per Appendix A. | Increase use of cost effective dispensing routes for outpatient medicines: - Implementation of agreed transition plan for increasing use of cost effective dispensing routes for outpatient medicines(plan to be developed by drug category to take into account patient population).Transition to agreed cost per item reimbursement approach as per Appendix A.  |
| **Trigger 4** | Improving data quality associated with outcome databases (SACT and IVIg) :–All hospitals submit required outcomes data (SACT, IVIg) in agreed format fully, accurately populated in agreed timescales. Implementation of agreed transition plan for increasing data quality. | N/A |
| **Trigger 5** | N/A | Reporting of all NHS England excluded drugs dispensed data to the Trust pharmacy systems. This will enable 100% national coverage of excluded drugs data, when uploaded to the Pharmex data system. This is to include all routes of dispensing, such as; Outsourced out-patient dispensing, Out-patient dispensing and Homecare services. |

 |
| **Percentages of Target Payment per Payment Trigger**The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

|  |  |  |
| --- | --- | --- |
| **Percentages of Target Payment per Trigger** | **2017/18** | **2018/19** |
| **Trigger 1** | 33% | 33% |
| **Trigger 2** | 17%% | N/A |
| **Trigger 3** | 33% | 33% |
| **Trigger 4** | 17%% | N/A |
| **Trigger 5** | N/A | 34% |
| **TOTAL** | 100% | 100% |

 |
| **Partial achievement rules****Year One**Trigger 1a: New patients Achievement for 90%patients => 100% of target payment 80% patients => 75% of target payment70% patients => 50% of target paymentTrigger 1b) Existing patientsAchievement of 95% or over of target = 100% of target payment90%-94% of target achievement = 75% of target payment75%-89% of target achievement = 50% of target paymentTrigger 1c) N/A**The “target” refers to the threshold set out in Section C5.**Split of Trigger 1 payment between new and existing patients should be proportional to expected spend, absent the CQUIN, or each group.Trigger 2: If the target is not fully achieved but 100% of the critical fields in MDS are correctly entered and submitted on time with bottom line value from MDS matching drugs line on Aggregate Contract Monitoring Dataset => 50% of target paymentTrigger 3:If over 90% of the categories in the transition plan have migrated => 75% of target paymentIf 75-89% of categories in the transition plan have migrated => 50% of target payment Trigger 4: No payment for partial achievementTrigger 5:N/A**Year Two**Trigger 1a: New patients Achievement for 90%patients => 100% of target payment 80% patients => 75% of target payment70% patients => 50% of target paymentTrigger 1b): Existing patientsAchievement of 95% or over of target = 100% of target payment90%-94% of target achievement = 75% of target payment75%-89% of target achievement = 50% of target paymentTrigger 1c)Switching patients to treatments in line with agreed commissioning position. Targets will be agreed locally as and when the policy/guidelines are published.Trigger 2:N/ATrigger 3: If above 90% of the categories in the transition plan have migrated => 75% of target paymentIf 75%-89% of categories in the transition plan have migrated = 50% of target payment.Trigger 4: N/ATrigger 5:No payment for partial achievement. |
| **Definitions**Trigger 1

|  |  |
| --- | --- |
| **Numerator** | 1a/b) Eligible patients receiving drugs available as best value generic/ biologic (list will be updated quarterly) - new patients and existing patients. 1c) Eligible existing patients receiving approved treatment or have stopped treatment as per policy/ guidelines. |
| **Denominator** | 1 a/b) Patients eligible to receive drugs available as best value generic/ biologic (list will be updated quarterly) - new patients and existing patients.1 c) Patients eligible to switch or stop treatment in line with agreed policy/guidelines. |

Trigger 2

|  |  |
| --- | --- |
| **Numerator** | Mandatory fields including dm+d code completed accurately in MDS AND bottom line value from MDS |
| **Denominator** | Mandatory fields for completion AND drugs line value from ACM. |

Trigger 3

|  |  |
| --- | --- |
| **Numerator** | Number of drug categories transition to new cost effective dispensing routes. |
| **Denominator** | Total number of categories to be transitioned to new cost effective dispensing routes as set out in the agreed transition plan. |

Trigger 4

|  |  |
| --- | --- |
| **Numerator** | Specified fields completed accurately. |
| **Denominator** | Specified fields for completion (all mandatory and required fields for SACT; all indicators on Immunoglobulin Quality Dashboard).  |

Trigger 5

|  |  |
| --- | --- |
| **Numerator** | Dispensing data for all National Tariff excluded drugs submitted accurately to Trust Pharmacy systems(this includes all dispensing routes) |
| **Denominator** | Dispensing data for all National Tariff excluded drugs |

 |
| **C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**  |
| **Information for Benchmarking** as for evaluation. |
| **Information for Evaluation**Trigger 1 - Trust produced report each monthTrigger 2 – Commissioner produced monthly data quality compliance reportTrigger 3 – Trust produced report each quarterTrigger 4 – Commissioner produced quarterly data quality compliance reportTrigger 5 – Trust produced report each quarter against implementation plan  |
| **Reporting of Achievement against Triggers**Trigger 1 a&b – Year 1

|  |  |
| --- | --- |
| Milestones | Rules for achievement of milestones (including evidence to be supplied to commissioner) |
| Q1 17/18 | 90% of new patients receiving best value generic/ biologic product on Q1 list |
| Q2 17/18 | 90% of new patients best value generic/ biologic product on Q1 and Q2 list and 20% of existing patients receiving best value generic/ biologic product on Q1 list |
| Q3 17/18 | 90% of new patients receiving best value generic/ biologic product on Q1, Q2 and Q3 list and 40% of existing patients receiving best value generic/ biologic product on Q1 list and 20% of existing patients receiving best value generic/ biologic product on Q2 list |
| Q4 17/18 | 90% of new patients receiving best value generic/ biologic product on Q1, Q2 , Q3 and Q4 list and 60% of existing patients receiving best value generic/ biologic product on Q1 list and 40% of existing patients receiving best value generic/ biologic on Q2 list and 20% of existing patients receiving best value generic/ biologic product on Q3 list |
| Trigger 1a&b – Year 2 |
| Q1 18/19 | 90% of new patients receiving best value generic/ biologic product on 17/18 Q1, Q2, Q3, Q4 list and 18/19 Q1 list. 80% of existing patients receiving best value generic/ biologic product on 17/18 Q1 list and 60% of existing patients receiving best value generic/ biologic product on 17/18 Q2 list and 40% of existing patients receiving best value generic/ biosimilar biologic product on 17/18 Q3 list and 20% of existing patients receiving best value generic/ biologic product on 17/18 Q4 list. |
| Q2 18/19 | 90% of new patient’s best value generic/ biologic product on Q1 and Q2 list and 20% of existing patients receiving best value generic/ biologic product on Q1 list. |
| Q3 18/19 | 90% of new patients receiving best value generic/ biologic product on Q1, Q2 and Q3 list and 40% of existing patients receiving best value generic/ biologic product on Q1 list and 20% of existing patients receiving best value generic/ biologic product on Q2 list |
| Q4 18/19 | 90% of new patients receiving best value generic/ biologic product on Q1, Q2 , Q3 and Q4 list and 60% of existing patients receiving best value generic/ biologic product on Q1 list and 40% of existing patients receiving best value generic/ biologic on Q2 list and 20% of existing patients receiving best value generic/ biologic product on Q3 list |

Trigger 1c – Year 2

|  |  |
| --- | --- |
| Milestones | Rules for achievement of milestones (including evidence to be supplied to commissioner) |
| Q1 18/19 | TBC locally – following publication of policy/guidelines |
| Q2 18/19 |
| Q3 18/19 |
| Q4 18/19 |
|  |

Trigger 2 – Year 1

|  |  |
| --- | --- |
| Milestones | Rules for achievement of milestones (including evidence to be supplied to commissioner) |
| Q3 17/18 (Ms 7-9) | Fully and accurately populated MDS submitted on time with bottom line value from MDS matching drugs line on ACM\* |
| Q4 17/18 (Ms 10-12) | Fully and accurately populated MDS submitted on time with bottom line value from MDS matching drugs line on ACM |

\* Subject to dm+d implementation timetable as agreed with NHS DigitalTrigger 3 – Year 1 & 2

|  |  |
| --- | --- |
| Milestones | Rules for achievement of milestones (including evidence to be supplied to commissioner) |
| End of Q1 | Approval of transition plan (year 1; review ); review and refresh of transition plan (year 2) |
| End of Q4 | Implementation of transition plan and delivery of target dispensing % through designated cost effective dispensing routes at the designated cost per item tariffs  |

Trigger 4 – Year 1

|  |  |
| --- | --- |
| Milestones | Rules for achievement of milestones (including evidence to be supplied to commissioner) |
| Q1 17/18  | Approval of transition plan |
| Q2 17/18  | Fully and accurately populated submission in line with agreed transition plan |
| Q3 17/18 | Fully and accurately populated submission in line with agreed transition plan |
| Q4 17/18 | Fully and accurately populated submission in line with agreed transition plan |

Trigger 5 – Year 2

|  |  |
| --- | --- |
| Milestones | Rules for achievement of milestones (including evidence to be supplied to commissioner) |
| End of Q1 | Approval of transition plan. |
| End of Q4 | Implementation of transition plan and delivery of target of inclusion of all National Tariff excluded drug data in Trust pharmacy systems. |

 |
| **Reporting Template requirement**: A new reporting template and process for completion of Trigger 1 and 3 will be made available from in May 2018. |
| **C6. Supporting Guidance and References** |
| Trigger 1a/b Supporting information  |
| **Section D. SCHEME JUSTIFICATION** |
| **D1. Evidence and Rationale for Inclusion**  |
| **Evidence Supporting Intervention Sought**The Carter Review found significant variation in total pharmacy and medicines costs across acute trusts. It states that some of this variation may be explained by the presence of teaching or specialist services, however, at this high level, if all trusts looked at how they might achieve the average cost then the NHS could save at least £800m. Recommendations include:* Trusts should through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks
* Trusts that have not currently outsourced their outpatient dispensing services should ensure their HPTP plans include a review of these services and have a plan in place for improving productivity and efficiency, including consideration of alternative supply routes, such as homecare providers or community pharmacies.
* Trusts should seek to reduce their medicines bill through best choices and from actively monitoring market developments, such as the launch of biosimilar products
* NHS Improvement and NHS England should establish joint clinical governance to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway
* each trust’s Finance Director, working with their Chief Pharmacist, ensuring that coding of medicines, particularly high cost drugs, are accurately recorded within NHS Reference Costs
* monitoring clinical outcomes of medicines to meet clinical needs and to support their optimal use
* Trusts identify the true value and scale of the opportunity for rationalisation and integration of hospital pharmacy procurement and production, developing an NHS Manufactured Medicines product catalogue and possibly moving towards a four region model for these services.

The National Audit Office report on the commissioning of specialised services in the NHS has also highlighted issues which need to be addressed to allow NHS England to achieve better control of rising drug costs including:* By working with providers to guarantee the volumes of drugs to be purchased, the NHS could potentially secure better value;
* Ensuring high cost drug data and patient outcomes is collected consistently is analysed to reduce unwarranted variation
 |
| **Rationale for Use of CQUIN incentive**This CQUIN aims to support the procedural and cultural changes required to fully optimise use of medicines commissioned by specialised services, i.e. ensuring that HPTP plans reflect NHS England priorities to improve value from medicines and reduce unwarranted variation. The CQUIN monies will be used to fund additional pharmacy staff to deliver the initiatives and also to ensure that each Trust’s HPTP plan is supported at Trust Board level.Changes required will materially reduce commissioner costs; hence it is appropriate for CQUIN support in its funding.  |
| **D3. Justification of Size of Target Payment** |
| The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:The expectation is that a dedicated resource of 1 wte pharmacist time plus admin / analytical support would be required for every £25m of drugs expenditure.A £25m drugs budget would equate to a payment target of £250,000 (£25m x 1% = £250k)The full year cost of pharmacist plus admin / analytical support is estimated at £167,000. £167,000 x 150% = £250k. |
| **D4. Evaluation** |
| Formal evaluation is not sought for this scheme. |