Borders NHS Board

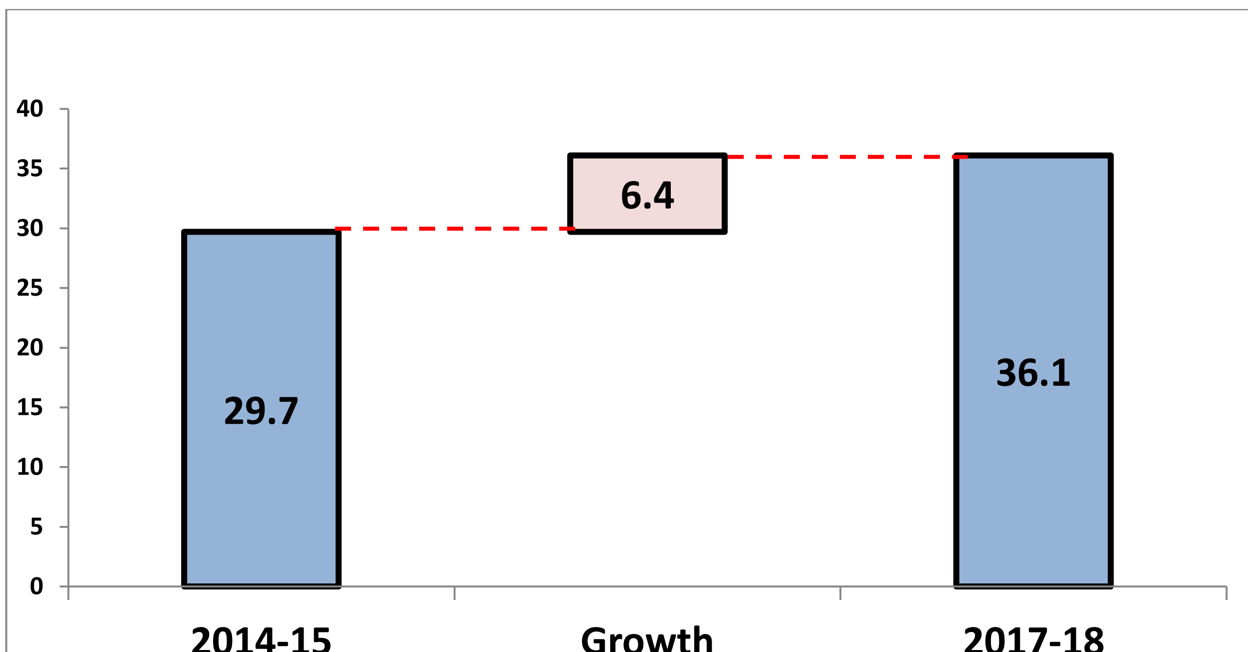
PRESCRIBNG COST CONTAINMENT

Aim

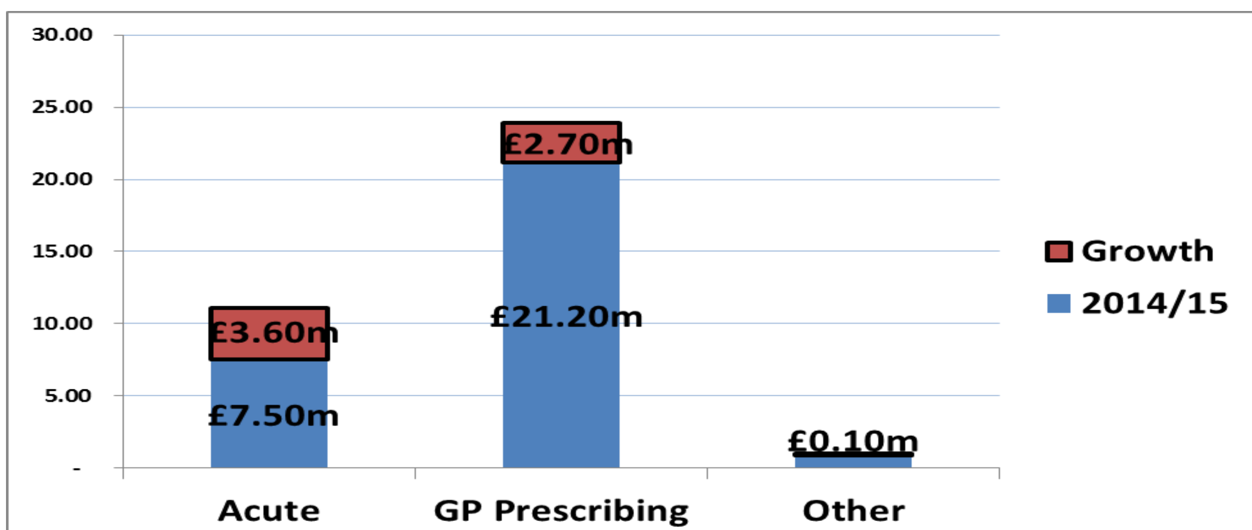
To summarise proposals to be agreed with clinicians on containing prescribing costs.

Background

Prescribing costs are rising faster than NHS Borders' annual uplift. Growth of prescribing costs over the last 3 years was £6.4< or 22% (net)



Expenditure growth can be broken down as follows



Options for consideration – Secondary care

Within secondary care the main reasons for increased costs are due to volume growth through increased access to new medicines, new indications for existing medicines and extension of treatments choices to third and fourth-line options. The main areas of increase cost are:

	2014/15 £k	2017/18 £k	Growth £k	New Medicines	Volume Growth
Haem/Onc	2,860	4,044	1,184	2,189	(1,005)
Gastrointestinal	200	901	701	461	240
Neurology	221	958	737		737
Dermatology	14	401	387		387
Rheumatology	1,259	1,512	253		253
Ophthalmology	374	567	193		193
Diabetes	163	290	127		127
Urology	16	105	89		89
Other	2,301	2,353	(62)		(62)
Total	**7,522**	**11,131**	**3,609**	**2,650**	**959**

Over time, there has been a separation of responsibility for individual patient care and resource utilisation and if allowed to continue the cost of medicines could theoretically consume all available resources in NHS Borders. Senior clinical staff who commit these resources are best placed to decide on how to obtain greatest value from prescribed medicines as they hold the detailed knowledge of the patients within their service. With support and advice from pharmacy and finance they can ensure that we maximise the impact of NHS Borders' expenditure on medicines.

There are many activities underway to make savings within secondary care prescribing e.g. formulary review to include more cost effective options (dermatology, respiratory), drug switches (biosimilars for rheumatology, gastroenterology and haematology), restriction of product choice (oral nutritional supplements) and review of indications for drug use (lidocaine plasters). These alone will not deliver the required savings.

We want to engage clinicians in what reasonable action should be taken to contain costs where it is both sensible and possible given limited resources. This should include:

- discussions on local treatment thresholds,
- benefits assessment,
- resource transfer to ensure decisions and treatment are sustainable
- use unlicensed products where a licensed alternative exists
- ensuring cost effectiveness (setting a maximum cost per QALY) and
- possibly delay the introduction of new treatments

To take forward the above options it may be necessary to seek the view of the Central Legal Office since licensed medicines may legally be prescribed by any registered medical practitioner.

This work will start immediately and be presented back to the next Board meeting.

Options for consideration – Primary care

Within primary care volume growth has played a limited part in increased prescribing costs. Instead costs have increased due to drug tariff changes and drug shortages as well as demographic changes with people living longer with multiple long-term conditions.

Examples of key price increases (gross) by specific area are:

	14/15	17/18		
Cardiovascular	2,469	3,296	828	Oral anticoag and Volume
CNS	5,348	6,449	1101	Volume growth & Short Supply
Endocrine	2,884	3,086	202	Volume growth

Collaboration between GPs and senior Board staff is required to ensure the objective of containing primary care prescribing costs is met along with robust data to support decision-making.

To date the following actions have been taken:

1. Following a meeting with the GP subcommittee it was agreed to restrict prescribing of some medicines of low clinical value. A letter has been sent to GPs and work will start from 1st September 2018.
2. Project support from the Better Borders team to increase the pace of change. The Prescribing Support Team (PST) will work with GPs on a number of key areas. The aim will be to work on the same change in every practice and to complete within a set period of time. The first project started in August with lidocaine plasters and will be completed in September 2018
3. Managing variation – all practices will receive direct feedback on their prescribing patterns compared with other Borders' practices on a regular basis. This will be followed up by the PST with support and guidance on how to reduce unnecessary prescribing, polypharmacy and costs.
4. Work on the new GMS Pharmacotherapy service has started in a number of practices and will be rolled out over the course of the next 30 months to all practices. Efficiencies will be generated from individual patient reviews and a unified repeat prescribing system across all practices.

Areas that could be considered and will require further consultation with GPs include reviewing thresholds for treatment and support for GPs and their staff to direct patients with self-limiting conditions, such as hay fever and soft tissue injuries, to community pharmacies.

Options for consideration – Patient and Public

A communication plan will be required to inform patients and the public of the part they can play in containing the cost of prescribing and thereby protect investment in medicines and other services.

Summary

The paper presents a number of options to help contain prescribing costs. These options will require discussion with senior clinicians and GPs and brought back to the Board for sign off.

All of this will be supported by and in accordance with the wider discussion on principle of practicing realistic medicine.

This paper has not been reviewed by any other committee.

Recommendation

The Board is asked to **note** the approach to be taken to support prescribing cost containment.

Policy/Strategy Implications	Supports the Code of Corporate Governance though achieving financial balance
Consultation	Medical Director, Finance
Consultation with Professional Committees	None
Risk Assessment	None
Compliance with Board Policy requirements on Equality and Diversity	An EIA will be required
Resource/Staffing Implications	None

Approved by

Name	Designation	Name	Designation
Dr Cliff Sharp	Medical Director	June Smyth	Director for Strategic Change

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