PM Healthcare
PROGRESS THROUGH PARTNERSHIP

Q&A panel questions

Future Priorities for High Cost/Medicines Value & Pharmacy: A discussion to cover key issues and thoughts for the year ahead

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Should ICBs take commissioning decisions on a region wide basis, like the South East Regional Medicines Optimisation Group?

I think it depends on the topic. It is useful to have a regional position on some big ticket items.

How do you manage medicines supply chain especially with lots of issues with getting hold of medicines?

It depends on the shortage - for important ones you might need a system wide approach (e.g. Pancreatic enzyme replacement).

Do you feel that enough system leaders actually understand, live and demonstrate system leadership?

Not all. Some are still in the commissioner space and don't see the value of working as partners with their provider colleagues.

How are you engaging your local population into providing solutions for health and care?

Lots of different ways (patient participation groups, elected representatives, specific therapy groups) but don't feel we have cracked it.

Is there joined up review of IFR/cohort funding approvals between ICBs to identify areas of inequity for prioritisation? Or plans for this in the future?

There is a regional priorities committee which could consider a policy for a cohort of patients who have been through the IFR process.

How much do you feel that convoluted governance structures within the ICB limits the decision making and implementation of medicines value projects?

None.

How are you measuring the value of medicines as opposed to the cost?

Via indicators and frameworks such as QOF, CVD Prevent etc.

Are you considering evolving beyond one-year budgets to facilitate innovation (access to more expensive treatments that may have longer term economic benefits)?

Thinking yes, practically is somewhat different.

How are you supporting the shift from treatment to prevention and therefore the tension of savings occurring in other ICS budgets as whole system approach?

This is nothing new, the prevention agenda has been spoken about for decades.

How to you balance your ICS in year budgets vs the value of adopting GIRFT and the top down approach of treating earlier to prevent worsening patient outcomes?

This is BAU in terms of balancing the books and pushing the MO agenda for longer term gains.

Does VPAG and the notion that funding big ticket items will be clawed back by the NHS actually have any impact on your decisions?

Sadly not as the VPAG rebate isn't paid directly based on use and not into prescribing budgets.

How do you see the role of incentivisation for Trust teams to implement biosimilar switches in the context of significant financial pressures within ICBs?

Has worked well for years, and indeed NHSE have seen great success recently.

How can we ensure a rapid uptake of biosimilars as soon as they become available to reduce NHS costs when their is local resistance to their use?

Via incentives and having more discussions regarding value.

What support from NHSE and DHSC would help ICBs move to a greater focus on value and outcomes based approach to medicines?

We need to make a shift towards a value and outcomes-based approach to medicines. One area of support would be clearer national guidance on defining and measuring value in medicines, ensuring that all systems assess interventions consistently. Access to robust data analytics tools is also vital, as real-world outcomes data can drive evidence-based decision-making and highlight the long-term impact of medicines beyond immediate cost savings. Financial flexibility is another key factor; ICBs need the ability to reinvest the savings generated through medicines optimisation into wider patient care initiatives. NHSE could facilitate value-based procurement agreements, encouraging more innovative reimbursement models where funding is linked to patient outcomes rather than volume. A standardised framework for evaluating new medicines that incorporates both clinical efficacy and system-wide benefits would further support ICBs in making well-informed commissioning decisions.

How are you embedding outcomes and value in the real world to drive pathways and inequality?

To embed outcomes and value in real-world pathways, ICBs are trying to integrate population health management approaches to address variations in access and effectiveness across different patient demographics. This is tricky however because we just have no financial headroom and the bottom line is being pressured to breaking point, so the focus on outcomes isn't what it should be.

With ICBs having finite budgets how do you fund higher drug costs in ophthalmology? You have reached/reduced activity targets but how does £ get transferred?

Funding higher drug costs in ophthalmology within the constraints of a finite budget is a significant challenge. ICBs must prioritise treatments based on value, assessing the long-term benefits of medicines that may reduce hospital visits and improve patient outcomes. Difficult decisions are being considered about restricting or prioritising access. Generally though these are in block contracts so FTs are facing this challenge in the main but we are trying to reach a system solution.

As ICB's do you have a position on biological and generic HCD switch patient refusals for non clinical reasons and how these are managed to ensure equality?

We are adopting a 'biosimilar by default' policy. Some of our providers have this already and others are in the process of implementing this.

What would you say to primary care professionals who find cost incentive and medicines incentives schemes punitive to certain communities?

It's not feedback I've received so far, and we have done some really tricky stuff on low priority prescribing and medicines available over the counter. I think if they are done properly and co-designed with communities then they can address these concerns.

How do we balance need for harmonisation and standardisation with real value of locally appropriate designed pathways?

Variations in patient demographics, service capacity, and provider expertise, capacity and performance mean that rigid national approaches are not always be suitable.
Encouraging clinical leadership and co-design processes at the local level can ensure that pathway development reflects real-world needs while maintaining alignment with national guidelines. I still don't think we have the ICB-level forums to help share best practices yet, and this is something that NHS perhaps should have driven. As an example we should be exploring a single national formulary.

Do you support the embedding or funding pharmacy resource into secondary care where prescribing occurs to achieve improved outcomes?

Yes. Specialist pharmacists play a crucial role in medicines optimisation, ensuring that prescribing decisions are clinically appropriate, cost-effective, and aligned with patient needs. We need to get better at ensuring this expertise is built in at the commissioning stage.

Any tips/advice on influencing dispensing practices to support medicines value work programmes?

We've not managed to do this very successfully locally. Supporting dispensing practices with audit and feedback mechanisms can help them understand the impact of their prescribing choices and encourage alignment with national best practice, but in the absence of contractual levers it does require an interested 'lead' from within the practice..

How do you see delegation working in line with devolving budgets? Is there enough resource to manage this?

In my opinion there isn't a set aside budget to flow from the centre to ICBs i.e. we have not been told that staff from the centre will be drafted out to support local management of delegation. The role will probably lie with local clinical commissioning pharmacists who sit in Trusts to support wider across the ICBs. Specialist pharmacists will also be called on to help with delegation e.g renal. Resp and rheum pharmacist.
The money to pay for drugs will be devolved rather than resource in terms of staffing therefore local acute providers and ICBs will look at what resource (staffing) is needed similar to PBR and ICB commissioned drugs.

Should shared care be commissioned nationally e.g. within qof?

No, I don't think it should because that restricts local clinical need and may also restrict local DES schemes. There maybe be some benefits in national shared care commissioning but I cannot see GPs agreeing to this especially around some high-risk drugs eg DMARDs as they already feel like they are not best placed. If you look at the national shared care protocols that came out in 2022, we still have poor uptake of these.

Can more high cost drugs be effectively, efficiently and safely delivered in primary care with the right support? And if so, what would that look like?

Yes potentially, but that won't be through GPs (who at the moment do not prescribe some high risk drugs e.g DMARDS optimally) If you look at a pharmacist model that may work but you need highly developed specialist pharmacists supporting the roll out and uptake and this can work if you have a model from secondary care to support. However, who pays for this and where you get these specialists from needs to be considered.

Could you briefly outline how the ICBs' responsibilities differ from those of the CCGs with regards to HCD

CCGs each had a budget which is now pooled into one big envelope in the ICBS. The ICBS receive funding from NHSE based on the number of patients in the locality. There is not much difference as the CCGs also had a HCD lead which would lead the commissioning for all HCD similar to how they now do in the ICB.

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