Scottish Collaboration to Integrate Medicine Therapy between Out-Patient and In-Patient Sectors

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Personal Statements

- I had a major role in some of the initiatives which I shall describe. I have no ongoing role in medicines management in Scotland.
- I undertake paid consultancy work to a number of pharmaceutical companies (and others) around HTA of new medicines in the UK and elsewhere. My presentation will not refer to any individual medicines by name.

NHS Scotland

- Virtually monopoly payer and provider
- Universal coverage from general taxation
- Free at point of care
- No co-payment - all medicines provided free
- Secondary care provided by state-run hospitals
- Primary care provided by independent doctors
  - …but contracted to work within system ‘rules’
- Long history of ‘controlled prescribing’
  - Initially on good clinical grounds
  - Now also includes cost considerations

Recognising the Issues

- Early (1990) recognition of the problems
  - Primary care prescribing influenced by secondary care recommendation
  - Differential pricing of medicines in primary and secondary care (‘loss leaders’ in hospitals)
  - Clinical risks in use of too many medicines
    - …and in switching between medicines
  - Huge range of medicines stocked by pharmacies in community and hospitals

Initiation of Solutions

- Early introduction of joint working
  - Drug & Therapeutics (D & T) Committees involving primary and secondary care
  - Safe, quality prescribing the initial driver
  - Cost containment soon also a factor
    - …equally in primary and secondary care!
    - Single budget for healthcare (IP and OP)
  - Joint working then established as the norm
    - …and transferred to other areas of activity

Drug & Therapeutics Committees

- Local – one in each of 14 Health Boards
  - Short lines of communication to prescribers
- Multidisciplinary
- Joint primary and secondary care
- May include patient/public input
- Evidence-based approach
  - Full declarations of interest
  - Limited role for ‘key opinion leaders’
  - Part of the clinical community

The Medicines Lifecycle 2015

- Horizon Scanning
- Health Technology Assessment
- Formularies
- Communications
- Guidelines
- Managed clinical networks

- Impact on pricing/reimbursement

Horizon Scanning

- Identify pipeline medicines 12-24 months before launch
  - Confidential information from pharma
  - Report (‘Forward Look’) with limited numbers
- Focus on key medicines
  - High cost (to allow financial planning)
  - Service implications (to allow redesign)
  - Interface issues (to allow guidance/protocols)
- “no surprises” the aim!
- Now rolled out in UK (UK PharmaScan)

Health Technology Assessment

- New medicines assessment a challenge
  - Vital to keep Formularies up-to-date
  - Often significant cost implications
    - New medicines a cost pressure in all systems
- Pre-2001 - local assessments
  - Up to 14 assessments in Scotland - wasteful
  - Sometimes different decisions - divisive
  - Variable quality of decisions - open to challenge
- Since 2001 - Scottish Medicines Consortium

Scottish Medicines Consortium

- Consortium of existing (joint) DTCs
- 30-member committee
  - Doctors, pharmacists, patients, industry
  - Primary and secondary care at the table
- Advises on ALL new medicines
  - Primary, secondary and tertiary care
- Rapid process - 18 weeks
  - “shape practice, not change practice”
- Assesses value - not reference pricing!

SMC Review Process

- Process based on critical appraisal of a submission from the sponsor company
- Efficacy/effectiveness/safety reviewed by critical appraisal pharmacist
- Health economic case reviewed by health economist
  - Cost-utility (QALY) approach preferred
- Interaction with sponsor during review
- Review lasts around 6 weeks
- Burden of proof is on the manufacturer

Formularies

- All 14 Health Boards have a Formulary
  - Some individual, others shared
- All are developed jointly between primary and secondary care
- All apply equally in primary and secondary care
  - …no ‘carte blanche’ for specialists
- All prescribing is monitored and Formulary adherence assessed
- Some medicines limited to use on specialist advice (or even specialist prescription)

Non-Formulary Prescribing

- Obviously permitted if it can be justified
  - Individual patient treatment request possible
- Would be questioned if high in primary care
  - Prescriber would be individually targetted
- Might be questioned in ‘real time’ in hospital
  - Therapeutic substitution in some settings
  - Case-by-case justification before medicine used
  - Routine pharmacist monitoring of non-Formulary medicines, especially high-cost

Communication

- Formulary in paper/electronic version
- DTC minutes on website
- Regular Formulary updates
  - Good prescribing advice
  - ‘Drug of choice’ initiatives
  - Prescribing ‘newsletters’
- Communications are local
  - Maintain involvement and ownership
  - Content must follow national policy

Guidelines

- Almost all guidelines are jointly written
  - Input from primary and secondary care (IP + OP)
  - Full declarations of interest
  - Evidence-based rather than opinion-based
  - Interface issues usually specifically addressed
    - eg guidance on referral to secondary care
- Guideline advice informs Formulary content
  - …and *vice versa* - if the guideline recommends a class of medicine, the Formulary may name individual medicine(s)
- Guidelines follow SMC advice

Managed Clinical Networks

- Disease-specific networks
  - Cross-specialty (physician/surgeon/pharmacist..)
  - Across the interface - primary + secondary care
- Aim to cover all aspects of management
  - Diagnosis, investigation, monitoring
  - …also medicines use
    - Builds on interface experience gained in ADTCs
  - Facilitates managed introduction of new drugs
    - Only uses guideline/SMC-approved medicines
- Adherence to all aspects of MCN monitored

Joined-Up Working

- Formularies – informed by SMC advice, clinical guidelines and MCN protocols
- MCN protocols – informed by SMC advice and clinical guidelines
- Clinical Guidelines – informed by SMC advice

- Aim is uniform advice to prescribers
  - No ‘mixed messages’, especially on new drugs

Monitoring and Feedback

- Routine monitoring of OP prescribing
  - Electronic prescription in primary care
  - All collected and monitored centrally
  - Routine feedback + ‘academic detailing’
    - …to level of individual prescriber
- Pharmacy monitoring in IP care
  - Specialist pharmcists widely used
  - Moves towards electronic prescribing
  - Feedback to teams and individuals
    - eg - antibiotic stewardship

Locus of Control/Action

- Define where control/action best sited
- National
  - Horizon scanning
  - Health technology assessment
  - Guidelines
- Local
  - Formularies/protocols/clinical networks
  - Communications
  - Prescribing monitoring

Impact on Pricing/Reimbursement

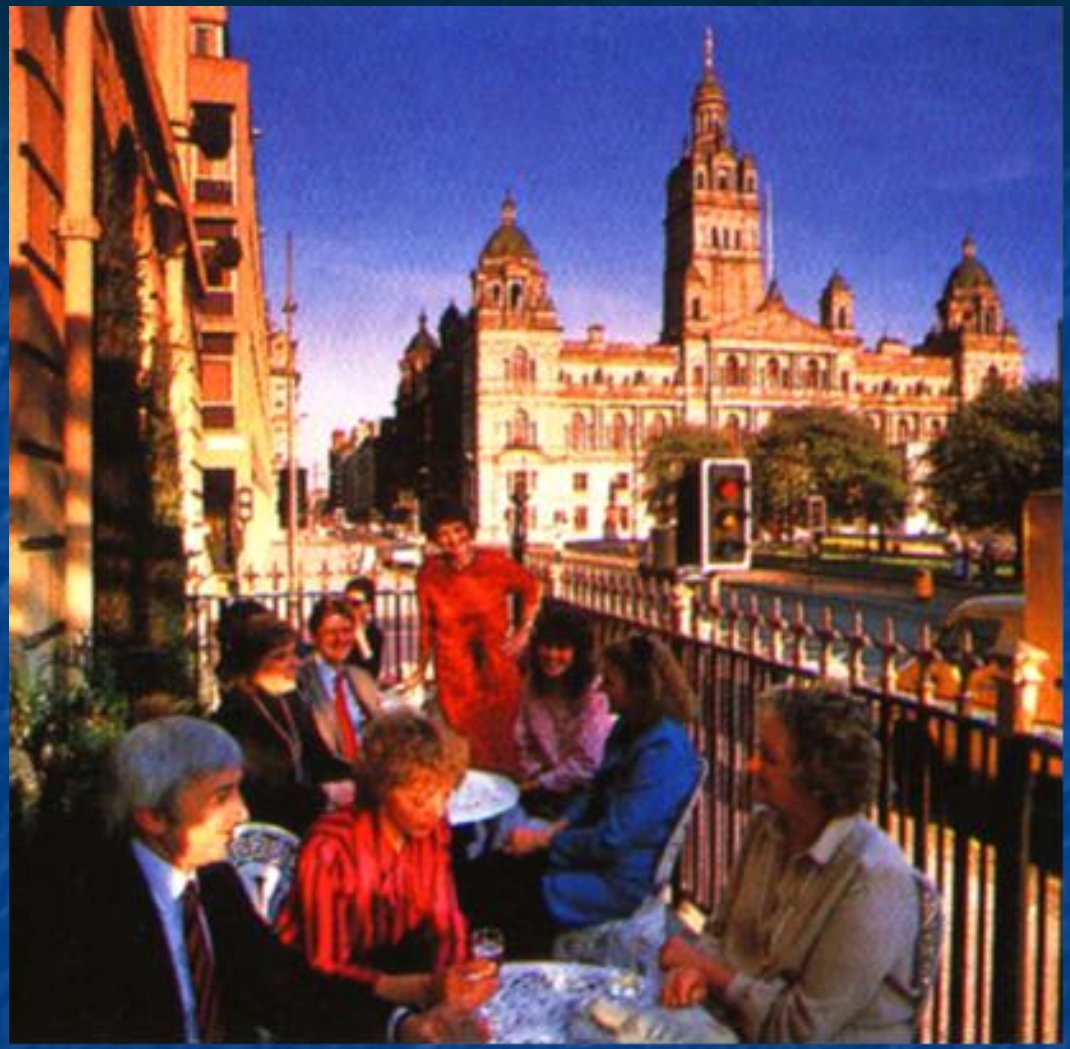
- Medicines pricing reserved to UK
- Local policies affect local pricing/expenditure
  - 85% of prescribing is ‘generic’ (by rINN)
    - 70% of dispensed medicines are generics
  - No ‘loss leaders’ in secondary care
  - No point in ‘influencing’ KOLs in secondary care
  - Value assessment promotes ‘patient access schemes’
    - Often simple discounts (exact amount may be secret!)
- Even a small (non-)country can negotiate better value-for-money

Why has this Worked?

- Collaborative process – IP + OP sectors
- Full clinician involvement and leadership
  - Part of the clinical community
  - Not driven by government or management
- Multi-stakeholder ‘as required’
- Evolutionary and progressive
  - Present position took over 10 years to reach
- Motivated by quality prescribing as well as cost-effective medicines use

The Scottish Experience

- Built over ~20 years of joint working
- Clinical benefits prime, then financial
- Needs culture of openness and transparency
  - …no conflicts of interest - see the big picture!
  - IP + OP, not IP v OP!!
- Needs careful ‘joined-up’ thinking/working
  - Difficult, bit not impossible, to achieve
  - Mixed messages unhelpful to everyone
- Now an accepted part of medicines use
  - …by clinicians and patients (and pharma!)



Danke vielmals!