Greater Manchester Shared Services

Implementation and principles of a Greater Manchester biosimilar gainshare agreement.

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Greater Manchester Shared Services
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on behalf of the Greater Manchester CCGs

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Document control

Document location

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Revision history

The latest and master version of this document is held on the Medicines Management SharePoint:

REVISIO N DATE	ACTIONED BY	SUMMARY OF CHANGES	VERSION
	Elaine Radcliffe	Initial draft produced	0.1
	Sarah Jacobs / Andrew Martin	Review, amendments and finalise draft document	0.2
	Sarah Jacobs	Condensed version	0.3
20/06/2017	Elaine Radcliffe	Review following comments from HCDSG and GMMMG	0.4
27/07/2017	S Jacobs	Final changes including removing appendices following July HCDSG	1.0

Approvals

This document must be approved by the following before distribution:

NAME	DATE OF ISSUE	VERSION
GMMMG HCDSG	June 2017	0.3
GMMMG HCDSG	July 2017	0.4
GMMMG	August 2017	1.0
GM DOCs	September 2017	1.0
GM CFO's	September 2017	1.0

Final version available on GMMMMG website.

1. Introduction

Lord Carter's review 'Productivity in NHS hospitals' (Carter, 2015) discusses ways in which hospital pharmacy and medicines optimisation can reduce the £6.7bn spend on medicines and £0.6bn on hospital pharmacy services. It highlights the variation in medicines costs and suggests £800m could be saved throughout the NHS if all trusts moved towards the average values whilst recognising that some variation is inevitable due to specialist services having higher costs.

> Lord Carter report quotes:
> 'Trusts should also seek to reduce their medicines bill through best choices and from actively monitoring market developments, such as the launch of biosimilar products.' (Carter, 2015)

When the patent of a drug expires, new drug products become available either as a generic, branded generic or biosimilar. The price of these products is usually lower than the original product in order to gain a foothold in the market.

Over time, once the new product has gained a significant market share, the originator manufacturer usually reduces the price of their product to bring it in line with the newer, cheaper product on the market.

Therefore in order to maximise the greatest savings over the longest period of time, a rapid implementation of the newer, reduced cost drug at the earliest possible opportunity is necessary.

2. Purpose

This document sets out how collaborative arrangements between CCGs and trust providers can work together to create initiatives that achieve better outcomes for patients and greater efficiencies in the use of biosimilar medicines.

This paper sets out arrangements which can be implemented quickly. This will maximise savings for the NHS and will be useful as additional biosimilars come to market over the next few years.

3. National schemes

NHS England has set a CQUIN for the acute trusts following Lord Carter's report:

> NHSE CQUIN G3 quote:
>
> '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' (NHS England, 2016)

CQUIN G3 is a two year scheme and the implementation is split into different thresholds for new starter patients and existing patients.

4. Greater Manchester

In Greater Manchester (GM) we hope to deliver improvement to health and wellbeing as fast as possible.

> Greater Manchester Health and Social Care Partnership quote:
> "Our vision is to ensure the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million people living in our region" (GMHSC Partnership)

The early release of any savings early will allow quicker reinvestment into services for our population to help achieve this ambition.

Uptake of biosimilar infliximab after its release in 2015 across GM has been slow compared to other parts of England. GMMMG would like to make GM a leader in the adoption of more cost effective medicines.

Swift uptake of biosimilars, and therefore increased savings, happen where CCG commissioners and trusts have negotiated a gainshare agreement early prior to or at the time of the launch of a new product.

Negotiations around the gainshare have been difficult to progress in some trusts as there is no accepted standard format. This document sets out the standard principles for gainshare across GM so that swift implementation can occur in all 8 GM trusts.

5. Responsibilities

1. Medicines optimisation teams are responsible for assessing and consulting on the clinical content of gain-share opportunities and managing the approval process through the nominated committee.

2. Trust providers of NHS services are responsible for assessing and developing gain-share opportunities and presenting in the standardised format approved jointly with commissioners.

3. GMMMG High cost drugs subgroup (HCDSG) is responsible for the approval of gain-share opportunities, through assessment of clinical, commissioning and financial considerations/implications.

6. Principles

1. Gainshare will apply to identified potential savings on pass through costs of PBR excluded drugs where a significant change in trust process is required.

2. Gainshare will apply to all patients being treated for CCG commissioned indications in any of the 8 GM trusts.

3. All gainshare arrangements will follow the standard GM format so that fewer negotiations are required and faster uptake can be achieved.

4. Gain-share arrangements will be based on a 50/50 split unless otherwise agreed on an individual scheme basis.

5. Savings are calculated as cost of the originator product in the month of dispensing minus cost of the cheaper version in the month of dispensing, against individual patient lines.

6. Gainshare costs will be identifiable monthly in a separate line attributed to the correct individual patient within the SLAM or SLAM backup data.

7. Gainshare can be applied for 2 years with ongoing review.

8. The gainshare period can begin three months after the product is made readily available. This date will be agreed by HCDSG and communicated to all providers. Exceptions might extend this period including product availability, stability data and compounding issues. All exceptions should be agreed locally.

9. Any resource implications required for implementation will be funded from the gainshare payment over the 2 year period, either up-front or ongoing.

10. Trusts and commissioners to work together to identify gainshare opportunities, and raise for discussion and agreement at GMMMG HCDSG.

11. Contract prices for HCD should be made available to the commissioners (CCGs) or their agents (GMSS) when requested.

12. All schemes to be approved by the GMMMG HCDSG, CCG directors of finance and representative of provider trust.

13. Where agreed and available Blueteq must be in place for applicable services and data supplied at the correct level (in line with contract and HCD/ homecare service specification).

14. GM gainshare principles should be included as a contract variation with trusts to ensure contractual levers are available to encourage implementation.

15. These arrangements apply to medicines funded by CCG commissioner.

7. Definitions of terms used

High Cost Drugs (PbR excluded): Drugs excluded from national tariff, paid on a pass through basis by CCGs and NHS England.

Homecare: Medicines supplied and, where applicable, administered through a third party homecare provider. Procurement is managed centrally or through trust providers.