A NEW SCHEMES

GE3: Medicines Optimisation

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	Two years
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 generics, biosimilars 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.	
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 Two years
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: UNIVERSAL UPTAKE
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 final CQUIN scheme will reflect the development needs of each Trust 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. The CQUIN and contract covers the first 2 years of the programme and is designed to support Trusts 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:

<0.6% 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 £150,000.

Year One: 0.6% of the 2017/18 contract value for tariff excluded high cost drugs

Year Two: 0.6% 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 best value medicines as they become available - Adoption of best value generic/ biosimilar products in 90% new patients within one quarter of being made available. Adoption of best value generic/ biosimilar products in 90% existing patients within one year of being made available (except if standard treatment is < 6 months)	Faster adoption of best value medicines as they become available - Adoption of best value generic/ biosimilar products in 90% new patients within one quarter of being made available. Adoption of best value generic/ biosimilar products in 90% existing patients within one year of being made available (except if standard treatment is < 6 months)

Trigger 2	Improving drugs MDS data quality to include dm+d code and all other mandatory fields – All Trusts 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	Increase use of cost effective dispensing routes for outpatient medicines including transition to cost per item reimbursement approach – 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)	Increase use of cost effective dispensing routes for outpatient medicines including transition to cost per item reimbursement approach – 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)
Trigger 4	Improving data quality associated with outcome databases (SACT and IVIg) – All Trusts submit outcomes data (SACT, Ivlg) in agreed format fully, accurately populated in agreed timescales	N/A
Trigger 5	N/A	Reviewing and switching existing patients to treatments in line with policy/ consensus guidelines – Existing patients reviewed and moved to appropriate regimen as per guidelines, e.g. HIV, MS

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**	**2017/18**
Trigger 1	28%	33%
Trigger 2	28%	N/A

Trigger 3	28%	33%
Trigger 4	16%	N/A
Trigger 5	N/A	34%
TOTAL	100%	100%

Partial achievement rules

Year One
Trigger 1:
90% of target achievement => 75% of target payment
75% of target achievement => 50% of target payment

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 payment

Trigger 3:
If over 90% of the categories in the transition plan have migrated => 75% of target payment
If 75-89% of categories in the transition plan have migrated => 50% of target payment

Trigger 4:
No payment for partial achievement

Trigger 5:
N/A

Year Two
Trigger 1:
90% or over of target achievement => 75% of target payment
75%-89% of target achievement => 50% of target payment

Trigger 2:
N/A

Trigger 3:
If above 90% of the categories in the transition plan have migrated => 75% of target payment
If 75%-89% of categories in the transition plan have migrated = 50% of target payment

Trigger 4:
N/A

Trigger 5:
No payment for partial achievement

Definitions

Trigger 1

Numerator	Eligible patients receiving drugs available as generic/ biosimilar (list will be updated quarterly) - new patients and existing patients
Denominator	Patients eligible to receive drugs available as generic/ biosimilar (list will be updated quarterly) - new patients and existing patients

Trigger 2

Numerator	Mandatory fields 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	Number of eligible existing patients on approved treatment or have stopped treatment as per policy/ guidelines
Denominator	All eligible existing patients receiving treatment for stated conditions

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 month
Trigger 2 – Commissioner produced monthly data quality compliance report
Trigger 3 – Trust produced report each quarter
Trigger 4 – Commissioner produced quarterly data quality compliance report
Trigger 5 – Trust produced report each quarter

Reporting of Achievement against Triggers

Trigger 1

Milestones	Rules for achievement of milestones (including evidence to be supplied to commissioner)
Q1 17/18	100% of new patients receiving generic/ biosimilar product on Q1 list

Q2 17/18	100% of new patients receiving generic/ biosimilar product on Q1 and Q2 list and 20% of existing patients receiving generic/ biosimilar product on Q1 list
Q3 17/18	100% of new patients receiving generic/ biosimilar product on Q1, Q2 and Q3 list and 40% of existing patients receiving generic/ biosimilar product on Q1 list and 20% of existing patients receiving generic/ biosimilar product on Q2 list
Q4 17/18	100% of new patients receiving generic/ biosimilar product on Q1, Q2 , Q3 and Q4 list and 75% of existing patients receiving generic/ biosimilar product on Q1 list and 40% of existing patients receiving generic/ biosimilar product on Q2 list and 20% of existing patients receiving generic/ biosimilar product on Q3 list
NB	
Q1 18/19	100% of new patients receiving generic/ biosimilar product on Q1, Q2 , Q3 and Q4 list and 18/19 Q1 list and 90% of existing patients receiving generic/ biosimilar product on 17/18 Q1 list and 75% of existing patients receiving generic/ biosimilar product on Q2 list and 40% of existing patients receiving generic/ biosimilar product on Q3 list and 20% of existing patients receiving generic/ biosimilar product on Q3 list

Trigger 2

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

Trigger 3

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 dispensing % through designated cost effective dispensing routes at the designated cost per item tariffs

Trigger 4

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

	timetable
Q4 17/18	Fully and accurately populated submission in line with agreed timetable

Trigger 5

Milestones	Rules for achievement of milestones (including evidence to be supplied to commissioner)
Q1 17/18	≥ 20% of existing patients reviewed
Q2 17/18	≥ 20% of existing patients moved to approved regimen (or treatment stopped)
Q3 17/18	>40% of existing patients moved to approved regimen (or treatment stopped)
Q4 17/18	>60% of existing patients moved to approved regimen (or treatment stopped)

Reporting Template requirement: reporting template will be made available.

C6. Supporting Guidance and References

Trigger 1 Supporting information – illustrative current example of expected introduction of generics and biosimilars during the CQUIN period:

Drug	Year		Earliest expected effective date
Voriconazole	16-17	Q2	01/08/2016
Imatinib	16-17	Q3	01/01/2017
Rituximab	16-17	Q3	01/01/2017
Trastuzumab	16-17	Q4	01/04/2018
Velaglucerase alfa	16-17	Q4	01/04/2017
Caspofungin	17-18	Q1	01/07/2017
Kivexa®	17-18	Q1	01/01/2017
Peginterferon alfa	17-18	Q1	01/07/2017
Pegfilgrastim	17-18	Q2	01/10/2017
Bosentan	17-18	Q2	01/10/2017
Tenofovir	17-18	Q2	01/10/2017
MMF E/C	17-18	Q3	01/01/2018
Tadalafil	17-18	Q3	01/01/2018
Pegvisomant	17-18	Q3	01/01/2018
Omalizumab	17-18	Q2	01/04/2018
Abatacept	17-18	Q3	01/04/2018
Abiraterone	17-18	Q4	01/04/2018
Anidulafungin	17-18	Q4	01/04/2018
Adalimumab	18-19	Q1	01/10/2018
Everolimus	18-19	Q2	01/10/2018
darunavir	18-19	Q2	01/10/2018
Aprepitant	18-19	Q3	01/01/2019
Thalidomide	18-19	Q4	01/04/2019
Atazanavir	18-19	Q4	01/04/2019

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 £150,000 (£25m x 0.6% = £150k)

The full year cost of a pharmacist plus admin / analytical support is estimated at £100k x 150% = £150k.

D4. Evaluation

Formal evaluation is not sought for this scheme.

CA2 Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT)

Scheme Name	***CA2: Nationally Standardised Dose Banding for Adult Intravenous Systemic Anticancer Therapy (SACT)***
Section A. SUMMARY of SCHEME	
QIPP Reference	*[QIPP reference if any : Add Locally]*
Duration	One or Two Years

Problem to be addressed

Chemotherapy is the single biggest service area within NHS England's specialised commissioning spend. It is estimated that NHS England spends approximately £1.5 billion on the routine commissioning of chemotherapy, with drug costs (which are paid by NHS England as pass through payments) being 80% of this. There is a very high rate of annual cost growth of approximately 8%.

Standardisation of chemotherapy doses offers one avenue for achieving improved value in this area – with clear system wide benefits.

Traditionally, chemotherapy doses have been unique to individual patients based on a per kg calculation. Such specific dosing does not provide additional clinical or patient benefit and significantly increases time and costs of preparation and costs of drug wastage. Additionally, standardised dosing will allow standardisation of the chemotherapy products available by diluent, volume and labelling which will allow access to ready to administer chemotherapy from generic and NHS manufacturers.

Dose Standardisation is achieved through a standardised approach to dose banding across England. The approach is in line with the Efficiency and Productivity review undertaken by Lord Carter, which recommends the elimination of waste through a consistent approach to patient care. The HopMOp team have been closely involved with this initiative.

Dose banding can be described as a "system whereby doses of intravenous cytotoxic drugs are calculated on an individualised basis that are within defined ranges, or bands, and are rounded up or down to pre-determined standard doses.

Change sought

Implementation of nationally standardised doses of SACT across England using the dose-banding principles and dosage tables published by NHS England (developed through the Medicines Optimisation Clinical Reference Group).

It is intended that all NHS England commissioned providers of chemotherapy move to prescribing a range of SACT drugs in accordance with a nationally approved set of dose tables.

Providers will be expected to:

1. Have the principles of dose banding accepted by their local oncology and haematology teams.
2. Have the drugs and doses approved by their local formulary committees.
3. Have SACT prescribed in accordance with the doses of drugs listed in the national dose-

banding tables.
4. Agreement and adoption of standardised product definitions

This approach should expand on the 19 SACT agents with standardised dosing tables developed for 2016-17 – implementing standard doses for a new range of SACT agents.

Original List of 19 SACT Agents for Dose Standardisation in 2016-17 and onwards

Bendamustine
Bortezomib SC
Carboplatin
Cisplatin
Cyclophosphamide (Pick and Mix)
Docetaxel
Doxorubicin (Pick and Mix)
Epirubicin (Pick and Mix)
Fluorouracil (Pick and Mix)
Fluorouracil (single unit)
Gemcitabine (100mg/mL)
Gemcitabine (38mg/mL)
Irinotecan
Oxaliplatin
Paclitaxel
Pemetrexed
Rituximab (Infusion)
Vinblastine
Vincristine

Additional SACT Agents for Dose Standardisation in 2017-18 and 2018-19 and onwards

Amsacrine
Arsenic Trioxide
Azacitidine
Cabazitaxel
Carfilzomib
Cetuximab
Cladribine (Leustat)
Cladribine (LITAK)
Clofarbine
Cytarabine
Dacarbazine
Daunorubicin
Doxorubicin Lipsomal (Caelyx)
Etoposide
Fludarabine (IV)
Idarubicin
Mesna
Methotrexate
Mitomycin
Mitoxantrone
Nab-Paclitaxel
Pentostatin

Streptozocin
Thiotepa
Topotecan (IV)
Vinflunne
Vinorelbine (IV)

Additional Drugs will be added as new drugs and dose bandings become available.

Section B. CONTRACT SPECIFIC INFORMATION *(for guidance on completion, see corresponding boxes in sections C below)*	
B1.Provider (see Section C1 for applicability rules)	*[Insert name of provider]*
B2. Provider Specific Parameters. What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract? (See Section C2 for other provider-specific parameters that need to be set out for this scheme.)	2016/17[1], 2017/18, 2018/19 *[Adjust locally]* One/two years *(Adjust locally)* *[Other – as specified in C2.]*
B3.Scheme Target Payment (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: *[set sum £s 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.

[Adjust table as required for this scheme – or delete if no provider-specific information is required]

Provider specific triggers	**2017/18**	**2018/19**
Trigger 1: Baseline		
Trigger 1: Stretch level		

[1] I.e. scheme was contracted for first implementation in 2016/17, and this template is setting out requirements for 2nd (and perhaps 3rd) year of scheme.

Trigger 2: Baseline		
Trigger 2 stretch		
Trigger 3		
	[Add rows to match C4 requirements.]	

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.

[Specify variation of this approach if required]

Section C. SCHEME SPECIFICATION GUIDE

C1. Applicable Providers

Universal Uptake Scheme

All providers of Chemotherapy services that prescribe any of drugs on the listed drugs above.

C2. Provider Specific Parameters

The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)	SACT Agents prescribed by provider from the above list Number of Doses administered Number of Doses administered in accordance with national dose banded tables Number of SACT agents to be standardised in year one/year two

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:

<½% of the annual value of chemotherapy drug spend that is to be standardised by the end of Q4, for each year>.

To set the CQUIN payment amount on this basis, as is required, necessitates a judgement in advance of contract signing and thus in advance of formal baseline assessment of the intended scope and approximate value of the intended scope of dose standardisation in the financial year.

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	First Year of scheme	Second Year and Third year (where applicable)
Trigger 1:	Collection of baseline-data for the range of drug doses that are to be standardised as agreed with the commissioner	Collection of baseline-data for the range of drug doses that are to be standardised as agreed with the commissioner
Trigger 2	Local Drugs and Therapeutics committee have agreed and approved principles of dose standardisation and dose adjustments required.	Local Drugs and Therapeutics committee have agreed and approved principles of dose standardisation and dose adjustments required.
Trigger 3	Targets to be agreed for end of year achievement in relation to the % of doses standardised per drug. (number of SACT doses given of selected drugs that match to the standardised doses / number of SACT doses given of selected drug).	Targets to be agreed for end of year achievement in relation to the % of doses standardised per drug. (number of SACT doses given of selected drugs that match to the standardised doses / number of SACT doses given of selected drug).
Trigger 4	Trust agreement and adoption of standard product descriptions (where these are available) for individual chemotherapy drugs.	Trust agreement and adoption of standard product descriptions (where these are available) for individual chemotherapy drugs.

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	All Years
Trigger 1	10%
Trigger 2	10%
Trigger 3	60%
Trigger 4	20%
TOTAL	100%

Partial achievement rules

Triggers 1,2,4: All or Nothing.

For Trigger 3 partial achievement:
The Commissioner will be able to review the data submitted and, where exceptions apply, will be able to agree the full CQUIN payment. In particular where participation in a trial precludes the use of dose-banded SACT.

Definitions
For Trigger 3:
Numerator: number of SACT doses given of selected drugs that match to the standardised doses

Denominator: number of SACT doses given of selected drug

C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.

Reporting of Achievement against Triggers
Baseline Data on drug doses that are to be standardises as agreed with the commissioner

Quarterly reporting on achievement in relation to the % of doses standardised per drug.

Reporting Template requirement
A standard reporting template has been developed for the 17-18 CQUIN.

C6. Supporting Guidance and References

The Dose Standardisation Tables and further guidance are published here:
https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-b/b02/

Section D. SCHEME JUSTIFICATION

D1. Evidence and Rationale for Inclusion

The Efficiency and Productivity review undertaken by Lord Carter recommends elimination of waste through a consistent approach to patient care. The standardisation of chemotherapy dosing is supported by NHS England, through the Medicines Optimisation CRG, having considered the efficiencies to be achieved on a national scale by adopting a single approach.

In Scotland, where dose banding of SACT has been established for a number of years, it has been estimated that 60-70% of all SACT administered is in the form of dose banded preparations. There is still significant potential for the adoption of a single standardised set of doses for a range of SACT drugs across England.

Alongside standardised doses, the next step is also to standardise the chemotherapy products by diluent, volume and labelling. This is the precursor to accessing ready to administer chemotherapy from the generic and NHS manufacturers.

This approach will simplify the process for any Trusts who wish to outsource readymade chemotherapy syringes and bags. Outsourcing has the potential to further reduce costs to the NHS. Having a single set of national dose tables will allow NHS and commercial providers of outsourced chemotherapy to produce the same doses leading to economies of scale and efficiency.

Intended Benefits:

For Patient	For Commissioner	For Provider
Fewer dose calculation errors Reduced patient waiting times – chemo is ready to give Facilitation of Administration of chemotherapy on any chosen day Supports treatment of patients closer to home	Same doses used across every provider in England Reduced cost through: Reduced Wastage (by re-use of cancelled doses and avoidance of incomplete vial usage during production) Allows outsourcing of standardised chemotherapy products.	Reduced bespoke pharmacy preparation workload. Maximises opportunities for financial efficiency through outsourcing of standardised chemotherapy product. Fewer dose calculation errors. Reduction in prescription alterations. Quicker dispensing through use of pre-prepared doses.

Rationale of Use of CQUIN incentive

Incentivise the adoption, at pace, of standardised chemotherapy doses and products across England. The incentive payment will support providers with agreements that need to be reached with local oncology and haematology teams, approval of standardised doses at local formulary committees, agreement and implementation of standard product specification and

monitoring and reporting of progress in achieving dose standardisation.
D2. Setting Scheme Duration and Exit Route
It is anticipated that by the end of 2018/19 dose standardisation will be part of mainstream NHS delivery of chemotherapy and further incentivisation will not be required.
D3. Justification of Size of Target Payment
This is an estimated proportional payment to incentivise at pace and at scale adoption of dose standardisation
D4. Evaluation
Data collected through the scheme using the data-collection tool will be used to undertake a central evaluation of the scheme at the end of each financial year***.***