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Case study

High Cost Drug Audit at the Royal Free NHS Foundation Trust

Overview

Activity monitoring is an essential component of the commissioning cycle and allows the commissioner to see whether providers are delivering the care that is contractually mandated while also reviewing any quality concerns. Audit is a key tool that has been utilised by the Central Southern Collaborative team to ensure the appropriate use and charging of medication exempt from the Payment by Results (PbR) tariff (high cost drugs).

Expenditure on biologic drugs accounts for some of the highest pharmaceutical spend within Trusts, predominantly used in rheumatology, gastroenterology, ophthalmology and dermatology. Of the top 10 highest cost medications recommended by NICE in hospitals, all were exempt by the PbR tariff. The unrestricted and inappropriate use of biologic drugs places a large financial burden on the NHS.

In 2011, the Central Southern Collaborative Commissioning team undertook an audit into the prescribing and supply of high-cost drugs (HCDs) at the Royal Free NHS Foundation Trust (RFH). The audit highlighted quality improvements in the documentation of regimens and criteria for ongoing treatment, in addition to inconsistencies in charging and supply of HCDs.

Objectives:

- The primary focus of the review was to understand if monoclonal antibodies (adalimumab, etanercept, infliximab and ranibizumab), used in a wide variety of disease states, were being used in accordance with NICE recommendations.
- Another aim was to review the usage of renal transplant medication in accordance with best practice and local guidance.
- The audit investigated whether charges to the commissioner for these HCD were reasonable compared to the cost to the provider.

Our approach

Ensuring a robust, governance-led approach to an audit is important in obtaining meaningful results that can validate provider performance, inform a change in practice or challenge activity outside of contract.

An agreed rationale and methodology was developed by Optum clinical pharmacists. Specific audit documentation was developed to ensure consistency of data collection and only data required to complete the audit was recorded, observing both provider and our own governance arrangements.

A team of experienced auditors reviewed case notes for an identified cohort of patients and recorded disease states, treatment regimens and key criteria for ongoing monitoring of treatment. Working collaboratively with the provider, any issues identified were resolved efficiently with no disruption to service delivery for the provider. Costs for treatment were analysed using pharmacy dispensing and invoicing data.

Impact/key outcomes

Following in-depth analysis and reporting of the data collected, it was concluded that where NICE guidance was applicable, the patient cohort was in accordance with criteria for commencing treatment. There were, however, a number of instances where an assessment criterion for ongoing treatment was not documented, therefore, effectiveness (and continued funding) of treatment could not be validated.

Renal transplant medication was found to be in accordance with local guidance, however, the team identified opportunities for improvement due to discrepancies between the case notes and records of pharmacy supply as to the actual treatment regimen each patient was taking.

In addition, the audit revealed inconsistencies in charging for HCD when SUS and SLAM invoices were compared to provider pharmacy dispensing data. It was found that for some clinical specialties, an average of £8,089 per patient per year was charged to the commissioner despite dispensing invoice data of £2,007 per patient per year. Applied across the patient cohort audited, this identified a potential additional £164,950 invoiced to the commissioner.

The audit team provided detailed information of their findings which informed discussions with the RFH. Working in partnership to understand the inconsistencies in invoicing, it was discovered that the commissioner had been charged a fixed monthly price for HCD activity with a set price for a particular drug or group of drugs. This was charged to the commissioner regardless of supply to the patient.

Our expectation as commissioners is that funding for HCD activity is at a cost per case at actual price. We anticipate that providers procure medicines at the lowest possible price and take advantage of all contract purchasing deals available to them. Our findings led to a change in practise for the subsequent financial year by removing the fixed price invoicing of HCD activity, and contributed to a total of £208,376 in successful challenges delivered as an efficiency saving to the Thames Valley and Wessex Commissioners.

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