

NHMC Proposal for the Funding of Pharmacy Homecare Teams by Commissioners

March 2021 update

Purpose

The purpose of this document is for the National Homecare Medicines Committee (NHMC) to provide an updated model to NHS England (NHSE) and Clinical Commissioning Groups (CCGs) for the funding of NHS Trust Pharmacy Homecare Teams. The proposed funding model as set out in 2017, consisted of a recommended tariff per patient per annum payable to NHS Trusts. The tariff was represented as a sliding scale so that as the total number of homecare patients increases the associated payment per patient per annum decreases. This sliding scale requires updating to represent additional staff costs due to increases in the Agenda for Change PayScale. The principles behind this proposal remain.

There has been a similar funding model for pharmacy homecare teams in the Thames Valley and Wessex (TVW) region since April 2015 and the evidence of its effectiveness is summarised in Appendix 1.

Included within the model is a fee to support the creation of a Homecare Pharmacy Specialist post in each region across England. Within the Pharmacy Procurement Network, the relatively recent appointment of Regional Homecare Pharmacy Specialists in 4 regions of England and in Scotland has led to improved homecare services to patients. Appendix 2 provides more information about the Regional Specialist role. Thames Valley and Wessex estimates that the cost of funding the regional role would be approximately £5 per homecare patient per annum.

The acceptance of a national funding model would be accompanied by an expectation by the commissioners that NHS Trusts would work towards improved compliance with Royal Pharmaceutical Society (RPS) Professional Standards for Homecare Services in England¹ as demonstrated by a yearly audit of homecare services supported by the Regional Homecare Specialist. Monitoring of Key Performance Indicators (KPIs) for homecare services should also be linked to the funding model. All expectations would be detailed within the standard NHS Trust contract with its commissioners (see Table 2).

The IT systems which support Homecare services are likely to advance in the next 12-18 months with the strategic support of NHS Digital. It is expected that all NHS Trusts in receipt of funding will maximise efficiencies these new systems will release.

If the funding model is adopted nationally it is anticipated that this will supersede any local agreements in place between NHS Trusts and commissioners following discussions between the two stakeholders. It is expected that national adoption would take place mid-contract through contract variation arrangements.

Background

The homecare market is a growing market with patient numbers increasing by approximately 20% year on year. There are currently an estimated 463,000 homecare patients in the UK with an estimated spend of £3.2bn (March 2021 figures) which is comprised of approximately 90 – 95% of that amount being the drug spend and 5-10% being the delivery costs. Over the years many NHS Trusts have struggled to support the increase in homecare patient numbers with existing pharmacy staff and structures. Whilst the prescriptions are generated by the clinical teams, the clinical check and processing of the prescription, including invoice management is undertaken by pharmacy departments. Homecare services can be separated into two main categories; Pharma funded and NHS contracted schemes. The market is split into 70% Pharma funded and 30% NHS contracted services. In the Pharma funded homecare schemes the pharmaceutical industry, usually the Market Authorisation Holder (MAH), funds the delivery and nurse administration elements of homecare and the NHS funds the medication. In the NHS contracted services, the NHS funds the entire service including delivery, nurse administration and medication. In both types of service the NHS manages the service Key Performance Indicators (KPIs) and manages the governance of the service.

Context

Summary of the Funding Model

This proposed funding model, as represented in Table 1 below, details the total numbers of homecare patients in a particular Trust (CCG and NHSE patient numbers combined), the suggested number of staff required to manage a service that complies with the professional standards and the associated fee band. Fees range from £85 to £225 per patient per annum.

The model is designed to be administered in a flexible manner as agreed between the Trust and its Commissioners. Trusts and Commissioners may choose to invoice the administration fee to the appropriate commissioner (NHS England or CCG) on a patient by patient basis at agreed intervals or to negotiate a one off annual payment for the provision of homecare services payable as one sum or divided into 4 quarterly payments.

To help with the administration of the model the NHS Trust may wish to agree the fee band at the start of the contract and review once a year with commissioners.

Table 1 Funding model showing the fee per patient per annum dependant on homecare patient numbers

Max Patient Numbers	Suggested Pharmacy Team Numbers	Fee Band	Fee per Patient per Annum	Maximum Estimated Total Annual Cost to Commissioners
1-200*	1.1	Band 1	£234	£46,878
201-350	1.3	Band 2	£165	£57,750
351-500	1.9			£82,500
501-650	2.5			£107,250
651-1000	3.4	Band 3	£133	£133,000
1001-1200	3.9			£159,600
1201-1500	4.7			£199,500
1501-2000	5.6	Band 4	£112	£224,000
2001-2500	7.1			£280,000
2501-3000	7.5	Band 5	£96	£288,000
3001-3500	8.8			£336,000
3501-4000	10			£384,000
4001-5000	10.3			£480,000
5001-6000	15.7			£576,000
6001-7000	18	Band 6	£90	£630,000
7001-8000	20.3			£720,000
8001-10000+	24.5			£900,000

*To be used by exception – see below

Further explanation

In order to comply with Trusts Standing Financial Instructions, there needs to be separation of duties for the placing of orders, receipting of goods and the invoice authorisation. The management of repeat prescriptions, maintenance of accurate patient medical records, supplier performance monitoring and the management of complaints and incidents requires considerable resource, often irrespective of patient numbers.

For Trusts where patient numbers are very small, this results in a need for a minimum level of staffing required to manage homecare. Even if homecare is offered as an option for less than 200 patients, it is likely that there will be several homecare contracts that require regular review, engagement with multiple suppliers and a number of different clinical teams. In this case, if the geography allows and /or regional support is available, it would be possible for a small hospital to hold joint service review meetings with a neighbouring hospital or group of hospitals or the service review to be undertaken regionally.

The funding of pharmacy homecare teams would remain economically viable where there is no other zero rated VAT supply model. In TVW the Trust with the fewest homecare patients 90% of patients receive subcutaneous biologic medication (no delivery fee) and 7% antiretroviral (ARV) medication (delivery fee applies). The average VAT saving for one ARV patient is £881 per annum. Annual delivery charges of approximately £184 apply so the overall saving is approximately £697. Even if there were fewer than 200 patients receiving homecare, the cost of funding the pharmacy team falls well within the savings achieved by using homecare services.

However to increase savings even further, small Trusts should be encouraged to share the management of homecare in a 'homecare hub'. A regional homecare specialist would be able to facilitate both regional and cross-Trust working. The RPS homecare standards¹ state that, all Trusts should engage with the relevant commissioners before setting up new homecare services. The NHMC agreed "Homecare Risk Assessment – setting up new services" document also supports this process.

There are economies of scale, (as the numbers of patients increases, the numbers of staff required does not need to increase in the same proportion). However, Trusts providing services for a large number of patients usually provide more complex and high tech homecare services which require more highly trained and skilled staff.

Limitations of the Funding Model

This funding model relates only to the management of pharmacy homecare services and does not include cost of medicines, delivery of medicines, nursing fees and equipment where levied by the homecare provider. The pharmacy homecare service includes all processes undertaken by pharmacy excluding the clinical validation of the prescription. Where a prescription is generated following an outpatient appointment pharmacy will receive a fee which will cover the validation of the prescription. Where repeat prescriptions are written without the need for an outpatient appointment, pharmacy will receive no funding. In order to minimise the unpaid clinical validation work undertaken by NHS Trusts prescriptions should be written for 6-12 month periods where possible. It is estimated that in only a small minority of homecare services will prescriptions need to be written more frequently than out-patient attendance and therefore a service cost cannot be included in this model. Where NHS Trusts identify significant unpaid clinical pharmacy input to homecare services this should be negotiated separately with its commissioners.

This funding model is limited to the administrative burden of managing homecare services by pharmacy homecare teams. Where changes in clinical practice (e.g. introduction of biosimilar medicines or changes to medicine regimens) would result in the release of further savings but also carry an additional administrative or clinical burden, then these should be accompanied by additional CQUINS, benefit sharing schemes or incentive payments..

This model assumes that Chief Pharmacists will be given discretion on how to use the entirety of the funding to improve compliance with professional standards. The £5 fee per patient per year should be paid to the regional procurement team directly to support the Regional Homecare Specialist role.

Option Appraisal

There are 3 possible options;

- 1 Do nothing/ status quo
- 2 Adopt this funding model nationally
- 3 Adopt an alternative funding model

1 Do nothing /Status Quo

It is likely that the disparity in the funding of homecare teams that was evident in TVW which resulted in a disparity of homecare services, is replicated throughout the country. This is reflected at national level, where feedback from homecare companies and MAHs state that communication between the NHS and the homecare industry is improved where there are Trust pharmacy homecare teams and regional homecare posts in place.

Currently the TVW model is being considered by NHSE local teams and CCGs in the few regions where there is a regional homecare specialist. If the model is adopted in some regions but not others this will result in an improvement in services in a small number of regions, in turn resulting in a disparity in England. This is resulting in the same conversations and discussions being repeated numerous times, which is not optimal from an NHS efficiency point of view.

In areas where there continues to be no or inadequate funding and homecare services are not managed by a pharmacy homecare team, the following problems may arise:

Current homecare patient numbers may stagnate or be reduced

- patients may be repatriated to access Trust services rather than homecare services
- new homecare services (both NHS and pharma funded schemes) may not be implemented
- patients may not be able to access services
- there may be additional cost pressures for commissioners via VAT chargeable supply routes

Lack of data transparency with regards to data provided to the commissioners by Trusts

- inability of Trust to provide commissioners with accurate and reliable data
- inability of Trusts to cross charge commissioners correctly

Limited audit trail with regards to prescription management

- poor management of repeat prescribing requests and associated prescriptions
- risk of patients requiring urgent deliveries (with associated emergency delivery costs)
- risk of patients missing doses and suffering harm

Poor contract management and Key Performance Indicator (KPI) monitoring

- inability to prevent patient harm in case of homecare service provider failure
- inability to monitor and manage homecare provider level of service
- inability to monitor and manage the wider homecare market
- inability to claim cost of Trust intervention from homecare provider when service levels fail

Poor management of complaints and incidents

- poor communication with patients
- risk of preventable incident recurring

Little or no management of contract prices

- poor invoice management
- poor financial governance
- overcharging of medicines and homecare delivery charges to commissioners

If this model is not adopted homecare medicines services will not improve. Contract prices will not be monitored effectively which leads to avoidable cost pressures. Where data transparency and data quality is currently an issue, these problems will remain with the potential for the clarity of data to become worse without the possibility of pharmacy intervention and improvements.

Inadequate funding may also lead to some acute Trusts reviewing homecare services and reducing the number of new patients accessing homecare with alternative models of supply being adopted.

2 Adopt this funding model nationally

There are a number of advantages in adopting this funding model on a national basis. Not only will services improve in all Trusts but the individual Trust/commissioner contract negotiation process will be more equitable and efficient. The biggest improvements are likely to be in those Trusts with the poorest standards (and consequently highest risks) at present.

The Chief Pharmacist or equivalent in each Trust has been nominated by the Department of Health (DH) as the responsible Officer for homecare. In order to ensure a safe and effective homecare service it is important that Trusts

become increasingly compliant with RPS professional standards¹. Pharmacy homecare teams are ideally placed to monitor all aspects of the services and are experienced in the following:

Improved compliance to RPS standards

- improved governance (clinical, financial and operational)
- effective contract management and transparency
- clear audit trail for prescription management

Increased savings opportunities

- increased capacity to manage homecare services
- contract prices are monitored
- clear audit trail for financial savings
- compliance with Trust Standing Financial Instructions (SFIs)
- opportunities for increasing the number of homecare services
- compliance with Carter recommendations to increase efficiency savings

Improved safety

- Improved management of incidents and complaints
- Increased engagement with pharma and homecare companies
- Improved communication with pharma and homecare companies

Improved contract management

- repeat prescription requests
- prescription ordering and invoice process (excluding clinical validation)
- homecare service review meetings
- supplier performance and KPI reviews
- supporting switching of patients between providers wherever necessary

3 Adopt an alternative funding model

At the moment no equivalent alternative funding model has been proposed to the NHMC for adaptation or adoption. The NHMC communicates effectively with regions via either the regional homecare specialist where they exist or via the regional Pharmaceutical Market Support Group (PMSG) representative. As far as the NHMC is aware TVW is the only region to have had a regional funding model in place for 2 years with an associated regional audit and demonstrated improvement in homecare services since 2015. Devising an equivalent new model would delay the acceptance process and it would not be possible for multiple Trusts to demonstrate that any alternative model provides the necessary funding to ensure service improvements within a reasonable timeframe.

In 2009 Leeds Teaching Hospitals NHS Trust estimated the cost of managing homecare. At that time there were approximately 5000 homecare patients with the cost per patient per annum being estimated to be £50. This estimate was limited to procurement of medicines and the invoice process rather than the end to end service.

The homecare market has become increasingly complex in the last 8 years. The complexity of clinical services, supplier performance management and the management of complaints and incidents has grown significantly. Following the Hackett report and the subsequent publication of the RPS professional standards¹, all governance processes (operational, clinical and financial) have needed to be reviewed. The DH CMU and the NHMC have worked collaboratively on a national standardisation programme work stream, so that there is now a bank of national templates for many aspects of homecare.

The implementation of national recommendations will improve the quality and safety of homecare services as described above but this £50 fee is no longer sufficient to guarantee adequate service improvements.

Recommendation

It is recommended by the NHMC that this funding model is adopted. It is also recommended that regional homecare specialists are appointed in each of the regions in England. Consideration should be given to the appointment of regional specialists varying from Band 8a to 8b dependant on local arrangements and needs.

The NHMC reviewed the TVW funding model and adapted it for wider use. Feedback from NHSE Specialised Services and the Medicines Optimisation Clinical Reference Group is that NHS England agrees that a consistent model for funding homecare services is required and is a priority for the 2017/19 contract round.

References

1. Royal Pharmaceutical Society (RPS) Professional Standards for Homecare Services in England September 2013
<http://www.rpharms.com/support-pdfs/homecare-standards-final-sept-13.pdf>
2. Royal Pharmaceutical Society (RPS) Handbook for Homecare Services in England May 2014
<http://www.rpharms.com/support-pdfs/homecare-services-handbook.pdf>

Appendix 1.

Evidence of Effectiveness of the Model

There has been a funding model similar to this proposal for pharmacy homecare teams in the Thames Valley and Wessex (TVW) region since April 2015. The model was originally requested by the NHSE Local Area Team (LAT) as commissioners (NHSE and CCGs) had reported a disparity in the quality of homecare services throughout the region. The disparity seemed to be dependent on whether Trusts had a dedicated homecare team or not. Commissioners anecdotally reported that Trusts with a dedicated homecare team were able to provide comprehensive homecare annual reports, including clear financial data, whereas Trusts who managed homecare in a more disparate manner could not provide the same level of information.

The TVW region has had a network of homecare and procurement experts for a number of years with a dedicated regional homecare group since 2013. Trust pharmacy homecare representatives also reported a disparity in the quality of management of homecare services, with Trusts that received some funding being able to manage more homecare through the pharmacy departments than those without adequate funding.


The funding model is agreed in principle by each year by Trust Chief Pharmacists and Commissioning Pharmacists from NHS England (NHSE) and all CCGs by the Joint Chief Pharmacists Group. Trusts in TVW have the opportunity of using the funding model as a starting point for negotiations with NHSE and CCGs.



In TVW, there are 2 contract clauses in the NHSE/NHS Trust standard contract which relate to outsourced homecare provision. The first contract clause in the 2015-16 and 2016-17 contract related to the monitoring of compliance against a regional audit based on Hackett recommendations. The second clause relates to the monitoring of the national standard data set of homecare KPIs as determined by the Department of Health Commercial Medicines Unit (DH CMU) and the NHMC.

The first clause in the 2017-19 contracts will be updated so that compliance against the (RPS) Professional Standards for Homecare Services in England¹ is audited. This is a comprehensive set of standards that sets out the expectations for the end to end homecare process which includes all aspects of service.

The national standard data set of homecare KPIs includes measurements of both supplier performance and Trust performance. The dataset is reported to the NHS monthly by all suppliers

Table 2 Sample contract clauses for the standard NHS Trust/Commissioners contract

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
The Trust is required to provide assurance that the management of sub-contracted services via homecare supply is working towards compliance with the recommendations made in the Royal Pharmaceutical Society (RPS) Standards for Homecare Services and the RPS Handbook for Homecare Services in England		<p>The Provider will undertake an audit of its practice and processes to manage the sub-contracting/outsourcing of supply to homecare, against the RPS Professional Standards for Homecare Services in England.</p> <p>The following audit template will be used to measure compliance against RPS Professional Standards</p>  <p>National RPS standards HC audit template</p>	General Condition 9

		This audit will be undertaken in Q1 and a report submitted to NHS England in Q2 2016/17.	
The Trust is required to provide assurance that the subcontracting (outsourcing/homecare) of pharmaceutical services is performance monitored to ensure that patients continue to receive their medication via a quality assured service.		<p>The Provider will demonstrate that National Key Performance Indicators (KPIs) are agreed and monitored for all homecare providers.</p> <p> Appendix 10 DH CMU NHMC KPI data set.xl</p> <p>The Provider will submit a quarterly report to NHS England providing this assurance and identifying any issues that have arisen and action taken by the Provider.</p> <p> Homecare KPI blank report template.docx</p>	General Condition 9

The expectation is that for those Trusts that receive payments for the management of homecare, there will be an associated improvement in compliance with homecare standards. The Regional Homecare Pharmacist carries out a regional audit. The audit tool is approved by the Joint Chief Pharmacists Group. The results of the audit are shared with commissioners by the individual Trusts.

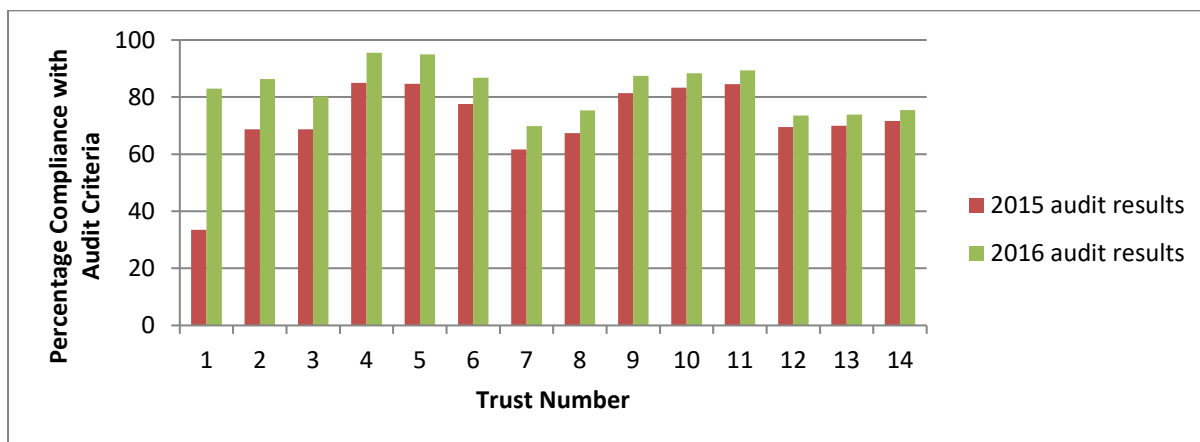
The results demonstrated below are based on the Hackett audits of 2015 and 2016. The Hackett audit toolkit is embedded below for information and reference. Improvement in the homecare service within each Trust is measured annually using the approved audit tool. Each criterion is scored out of 100 and then a section average and a total average score is calculated within the toolkit.



Homecare Blank
Audit 2016 Self asses

Figure 1 Chart to show the Regional Homecare audit results 2015 and 2106

The chart represents the Hackett audit results for 2015 (in red) and 2016 (in green) for the 14 Trusts in the Thames Valley and Wessex region with homecare services. The audit results are calculated as percentage compliance to the Hackett audit criteria for each Trust each year.



All Trusts demonstrated an improvement in compliance to the regional audit from 2015 to 2016.

Table 3 Summary of improvement scores by Trust funding category

Trust number	Funding Arrangement	Funding made available to Pharmacy Department	Average audit improvement score (%)
1,3,4,8	Commissioner funding based on the regional model	Yes, full amount	20.6
2,5,6,7	Self-fund a pharmacy homecare team either partially or fully	Yes, partially or fully	9.3
10,11,12,13,14	Commissioner funding based on the regional model	No	5.0
9	Commissioner funding (alternative model)	Partially	5.0

Table 2 clearly demonstrates that improvement scores broadly correlate to the amount of funding available to the Chief Pharmacists. This means that the Chief Pharmacists who received the recommended level of funding demonstrated the highest improvement scores.

Key Areas of Improvement

The initial audit in autumn 2015 highlighted a number of key areas for improvement that were consistent across a number of Trusts. By May 2016, most Trusts had made significant improvements in the following key areas:

- Commissioners have received an annual report on relevant homecare activities within the Trust
- Commissioners have received a list of homecare arrangements from the Trust
- Trust policies for the governance and management of medicines related Homecare have been approved by the appropriate Trust committee(s) (e.g. Medicine Management Committee MMC/Drugs and Therapeutics Committee DTC)

- Homecare arrangements have been approved and/or endorsed by the provider Trust MMC/DTC and an annual report has been made available for the Medicines Safety Group
- The numbers of homecare services offered to patients and managed by pharmacy increased significantly.

Key Areas of the Audit

The RPS Professional Standards for Homecare Services¹ and the associated RPS Handbook for Homecare Services in England² are comprehensive documents that lay out the recommendations for all aspects of homecare. There is an associated self-assessment tool which has been adapted for use as the basis of the audit from 2017 onwards. Areas that are monitored include (but are not limited to): The use of Pharmacy Computer Systems or an equivalent system for the recording of all homecare activity. This would ensure that there is a full audit trail for all homecare activity and also provide assurance that the correct prices are being charged by homecare service providers and that all drug and delivery charges are correctly cross charged to commissioners.

Joint approval of new homecare services by the Trust clinical teams, pharmacy, nursing, finance and commissioners
The use of the national Risk Assessment template, prior to new service implementation or a change in service.

Managing patient safety

Managing patient expectations, and the patient experience at outpatient appointments and via patient satisfaction surveys.

Communication with and the education of patients and clinical teams.

Communication between national, regional and local homecare experts

All aspects of staff training is also documented.

Appendix 2.

Regional Homecare Specialist Role

The regional post holders are able to demonstrate improved communication between the NHMC and local NHS Trusts. This effective engagement has led to faster adoption of NHMC standardisation work and governance recommendations and an associated improvement in services received by patients.

In addition to supporting the NHMC and the national homecare work plan other functions of the regional specialists include:

Shape National Strategy for NHS Homecare Services

- monitor and manage homecare market stability
- consult with MAHs and homecare providers with respect to existing and new service developments
- provide expert advice to MAHs and homecare providers

Manage Supplier Performance

- manage contract review meetings on behalf of smaller Trusts or groups of Trusts
- report and manage patterns of service defects and service failures centrally
- central review of homecare provider KPIs

Improve Financial Governance

- communication of CMU contract changes that affect homecare medicines regionally to Trusts and homecare providers
- review prices and ensure that commissioners are correctly charged
- actively monitor the prices paid by Trusts
- actively support Trusts with rebate claims when appropriate
- manage invoice discrepancies
- manage price and invoice disputes
- escalate financial and invoice issues within homecare providers

Governance of Complaints and Incidents

- facilitate training of NHS staff
- monitor incident trends at regional and national level
- intervene on behalf of Trusts in cases of complaints and incidents

Compliance with RPS Standards for Homecare Services

- carry out compliance audits to agreed standards
- produce gap analysis report and associated action plans for improvements at Trust level
- write individual Trust reports
- produce template homecare reports for commissioners

Communication

- Communicate with commissioners on a regular basis
- Attend regional commissioning pharmacist meetings
- Communicate issues that affect commissioners directly on behalf of a region
- Report to regional procurement groups and Chief Pharmacists

Organise and chair Regional Homecare Group meetings

- act as the mediator between the NHMC and Trusts
- improves efficiency and information flow is increased
- aid the sharing of information
- aid the sharing of innovative projects
- aid the implementation of innovative projects
- manage the tender process for regional homecare contracts
- facilitate training and education of Trust pharmacy homecare teams

Enable local teams to focus on local issues

- support Trusts with contract implementation
- provide expert support in all areas of homecare
- support and co-ordinate Trusts when switching homecare services between suppliers when required to by MAHs

- support and co-ordinate Trusts when switching homecare treatment regimens when required to by commissioners

Support Trusts when implementing complex pricing arrangements and/or patient access schemes (PAS) schemes