

IT'S ALL CHANGE FOR TRUSTS ON THE PROCUREMENT FRONT

Changes to the ways medicines are to be procured and funded were set out at the symposium of the Procurement and Distribution Interest Group (PDIG) of the Guild of Healthcare Pharmacists held in Coventry on 10 June. Rachel Graham reports

Certain generic medicines are to be procured for NHS hospital trusts in England using a national, rather than a regional, system, according to Howard Stokoe, principal pharmacist at the NHS Purchasing and Supply Agency (PaSA). Under the new system, suppliers submit a bid and, if successful, the contracts awarded to them can either be national, or for one of the six particular purchasing region(s). Contracts awarded for national supply are more likely to be longer in term and for a lower price, Mr Stokoe explained. In addition, separate bids are invited for each product line — there will no longer be pooling or basketing.

The product lines affected include oral generic preparations used in both hospitals and primary care and generic injectables and freeze-dried products used only in hospitals, Mr Stokoe continued. The closing date for sealed bids is in early August, with adjudication set to take place later that month. Contracts are to be awarded in September and run from 1 November. For some oral generic preparations, where supply to hospitals is only a small part of their market, an “e-auction” will take place after the sealed bids have been received.

During the adjudication stage, advice from the Pharmaceutical Market Support Group will be taken into account to ensure, for example, that any critical generic product shortages are anticipated and preventative measures taken, he said. The views of the National Patient Safety Agency will also be considered.

The new system has been introduced as part of the NHS Supply Chain Excellence Programme, designed to use the purchasing power of the NHS more effectively and to improve the transparency of sourcing. Data from trusts will be collected automatically under the new scheme and so it is hoped that a considerable amount of robust market intelligence will be built up. This can be used when deciding how to adjudicate bids and source products. The data will also aid benchmarking and audit. The expectation is

Ms Graham is staff editor at Hospital Pharmacist

A computer keyboard: using computers to bid at e-auctions for contracts to supply certain generic products to NHS hospitals is one of several procurement-related changes that are under way

that data on prices in Europe and the US will also be available in the system.

Mr Stokoe stressed that although the new contracts will definitely be implemented from November, existing arrangements with suppliers will be taken into account during the adjudication stage. He reassured delegates that PaSA were committed to making the introduction of the process as easy as possible for everyone. Allan Karr, pharmacy business services manager at University College London Hospitals NHS Trust and chairman of PDIG, told delegates that it is unclear whether the alterations to the system for procuring generics will be “a change for the better” — everyone will have to wait and see. [See p263 for additional reaction to the new generic products procurement arrangements.]

E-AUCTION EXPERIENCES

An e-auction has already been used by the Portsmouth Hospital NHS Trust to procure generic drugs, according to Neil Kemsley, deputy director of finance at the trust.

Mr Kemsley set out to delegates a “warts and all” account of how the auction was carried out. He explained that supplier companies who submitted sealed “paper bids” were informed that an e-auction on those lines was planned and invited to a “suppliers awareness seminar”. There was quite a bit of

hostility to the auction from many generic suppliers at the seminar, he said, with the decision not to “basket” lines being among those causing particular consternation.

The starting price for the on-line auction, which was run by UKprocure Ltd, was set as the best tender price. Each line was allocated a 30 minute slot. This was extended by 10 minutes if a bid came in in the last 5 minutes. Telephone support was in place, in case there were any technological problems.

Of the 52 companies who submitted sealed bids, 26 participated in the auction. Of the 109 lines in the original tender, 55 were put into the auction, with bids (185 in total) being offered for 33 of those. A total of £640,000 was saved from the whole tendering process, with approximately 10 per cent of that resulting from the auction itself, Mr Kemsley said. He added that he thinks that the trust benefited from suppliers not being told from the outset that the auction would take place.

In terms of learning from the auction experience, Mr Kemsley admitted that no real patterns emerged as to why there was competition on some lines and not on others. They did, however, receive good feedback on the performance of the technology. He advised others thinking about auctions to consider carefully what commodities to include and to enlist the help of experts, especially if it is their first experience of e-auctions.

“Big bang” for tariff funding is next year, says DoH

Reforms to the way NHS goods and services are funded are in the process of being introduced, according to Alistair Rose, economic advisor at the Department of Health. A national set of prices (ie, a tariff) is already in place, but only for patients admitted to hospitals and for “activity above the baseline.” The “big bang” for tariff funding happens next year, he said, when tariffs will apply to all admitted patients, as well as to outpatients, and patients using accident and emergency and critical care services. Tariffs will be rolled out into primary care from 2008.

Under the new “payment by results” system, the funding of the service provider is linked directly to the volume and complexity of the services they deliver, Mr Rose explained. “Spells” (which basically cover activity from the admission of a patient until their discharge) are used instead of “finished consultant episodes” and patients are classified into health resource groups (HRGs).

The general idea behind the tariffs is that money follows the patient. They link in with drives to increase patient choice and devolve spending power away from Whitehall and into local health economies. The tariffs also reward efficiency, Mr Rose

added, because they are based on average provider costs. Their publication also increases transparency and supports more effective planning.

Issues that have yet to be fully decided include whether the same tariff and cost weights will continue to apply to elective and non-elective admissions and how a long stay “trim point” (with reimbursement for additional days at a specified rate) will be defined. How the tariff should be adjusted for providers with significantly more patients with complex needs (ie, including where a proportion of patients in a particular HRG need high cost drugs) also needs consideration, Mr Rose said. Consultation about this latter issue will be on the Department of Health’s website shortly, he added.

For outpatients, a separate tariff for high-cost activities is proposed, to prevent trusts from being incentivised to admit such patients, Mr Rose continued. Adjustments to tariffs were also likely where implementing National Institute of Clinical Excellence guidelines or National Service Frameworks affects particular HRGs.

Other possible developments for the future include basing the tariffs on best prices (rather than average prices) and

introducing aspects of quality (rather than just quantity) into them.

As part of the introduction of the tariffs, some model service level agreements for those commissioning services are to be produced, based on a risk management approach. The reforms follow on from consultation documents produced last year, Mr Rose said. Publication of the responses to the consultation is imminent, he added, and the effects of the tariff funding will be monitored and evaluated over the next few years.

Delegates expressed some concern that, until the tariffs were rolled out fully, they might act as a block to primary-care led services. PDIG chairman, Allan Karr, again included the reforms in his list of changes where pharmacists will have to wait and see whether or not they are for the better.

Further information

More details on the structure and scope of tariff funding, trust financial regimes, costings and the commissioning and transition processes are included on the Department of Health’s website. Visit www.dh.gov.uk and search for “payment by results” or “core tools 2004”.

Home care evolution brings both challenges and benefits

It’s not necessarily as simple as it first appears, was the general message from Allan Karr, pharmacy business services manager at University College London Hospitals NHS Trust and chairman of PDIG, when discussing home care from a trust’s perspective. In particular, it is the fact that home care involves a service (rather than just a goods) component that brings challenges, he said. It can be difficult to audit a service, because only a snapshot of how the service is performing can ever really be provided. A great deal of attention also needs to be given to contracting for home care, so that it is clear who is legally responsible for what. Nationally-agreed performance standards might also be a good idea, he suggested. Future considerations include how home care services link in with the new “payment by results” tariffs and whether information technology systems will be able to keep up with developments in the market. Mr Karr concluded that “home care is a good idea for some patients.”

From the industry perspective, home care services have developed a lot from their roots as really just a home delivery service for bulky items such as dialysis fluids and enteral feeds, according to Jon Cohen, director of Healthcare at Home Ltd. A full range of services, including blood transfusions and help with stem cell products is now offered. The development has been driven by a combination of issues, including NHS reforms, an increase in “patient power” and the needs of the pharmaceutical industry, Mr Cohen added. Issues for the future include ensuring that the infrastructure is there to support the rapid growth in the market and accommodating delays to projects caused, for example, by waiting longer than expected for product launches. That the NHS often seems to work as “management by committee” can slow down the uptake of services, and is another challenge service providers have to meet, Mr Cohen added.