Chief Medical Officer Directorate
Pharmacy and Medicines Division
Dr Rose Marie Parr, BSc (Hons), MSc, PHD, FFRPS, FRPharmS
Chief Pharmaceutical Officer

T: 0131-244 9685
E: rosemarie.parr.@gov.scot

Lewis Macdonald
Convener
Health and Sport Committee
The Scottish Parliament

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Dear Lewis,

Health and Sport Committee – Supply and Demand for Medicines

Many thanks for your letter of 5 February and the opportunity to provide evidence to the Committee on what is an important topic not only for healthcare professionals and patients but to the people of Scotland.

The Committee have sought further information on a number of areas discussed during the evidence gathering session and I provided a response in this letter. Specifically the Committee requested information on data and data sharing, the ambition of a single patient record and implementation of Hospital Electronic Prescribing and Medicines Administration.

The development of a single electronic patient record is part of the Scottish Government's Health and Digital Strategy. The NHS Education for Scotland (NES) Digital Service was established in 2018 to deliver the National Digital Platform, which is a central part of this strategy by providing the infrastructure, products and services which will evolve how health and care technology is delivered, managed and experienced in Scotland. An important enabler for the single electronic patient record is the implementation of Hospital Electronic Prescribing and Medicines Administration (HEPMA) as it links the medicines prescribed, dispensed and administered in hospital to an individual patient. The digital platform provides the infrastructure to provide secure access to up-to-date high quality health and care information.

In terms of progress of HEPMA, I can confirm the following update on implementation:

- Four Health Boards (NHS Ayrshire & Arran, NHS Dumfries & Galloway, NHS Forth Valley and NHS Lanarkshire) have implemented or are close to completing implementation of HEPMA. A number of these Boards are now focusing on developing local reporting tools to maximise the use of available data to support service improvement, audit and monitoring.

- Nine Health Boards have commenced HEPMA implementation. NHS Lothian who are partnering with the State Hospital, will have their first site go live in March 2020. NHS

Greater Glasgow & Clyde has identified a preferred HEPMA supplier and will be starting the design and build phase shortly. Six Health Boards are working together as a North of Scotland collaboration.

- NHS Fife are at the procurement stage and are expected to finalise their preferred HEPMA supplier by the end of April 2020. NHS Borders and the Golden Jubilee National Hospital are developing their business cases.

My references to the challenges of HEPMA implementation are mainly in relation to developing the digital skills and capabilities across the whole health and care workforce sector which are needed to underpin the successful uptake and use of digital technologies such as HEPMA. As has been highlighted previously, this requires strong leadership to drive the transformation of services, support innovation and champion the use of information and knowledge to improve decision making and service delivery. We are making good progress and beginning to see real traction and pace in terms of HEPMA implementation. Factors contributing to that include the availability of appropriate financial resourcing, the introduction of a HEPMA Implementation Oversight Board and plans for a programme of shared eLearning and benefits realisation, supported by Healthcare Improvement Scotland.

Turning to outcome based pricing, one of the previous challenges to this has been the lack of a national system to underpin routine data collection on medicine outcomes. The Scottish Government has centrally funded a Cancer Medicines Outcomes Programme (CMOP), which is a collaborative programme between NHS Greater Glasgow & Clyde and the University of Strathclyde, to determine the impact and clinical outcomes of cancer medicines on patients in the real world.

Building on the foundations of the initial three year CMOP programme, they are now working towards a scalable and sustainable capability of expertise in cancer medicines intelligence to drive continued improvement in the safe and effective use of these medicines across Scotland. The lessons learnt in cancer can then be applied across other clinical priority areas.

In the Scottish Government we are committed to ensuring that the NHS in Scotland is supported to achieve the best possible prices for new medicines. Whilst medicine pricing is reserved and regulated through the UK Voluntary Scheme for Branded Medicines Pricing and Access Scheme (VPAS), a key objective for the Scottish Government during VPAS negotiations in 2018 was to establish binding commitments on Governments across the UK and the pharmaceutical industry to greater transparency and parity in medicine pricing. As a result, in January 2019 the new scheme introduced provisions that allow the UK Health Administrations to:

- Share the details of previously confidential pricing arrangements; and
- Imposes new responsibilities on pharmaceutical companies to achieve comparable arrangements that provide an acceptable value proposition in each part of the UK.

The current VPAS introduces a 2% cap on the growth in sales of branded medicines to the NHS for each year of the scheme, from 2019 – 2023. Pharmaceutical companies are required to repay the NHS for spending above the cap. Any companies wishing to opt in to the voluntary scheme are automatically subject to the provisions of the statutory scheme, as set out in the Branded Health Service Medicines (Costs) Regulations 2018.

Scotland's share of the rebate paid to the UK Government by the pharmaceutical industry via VPAS goes to the New Medicines Fund to fund the cost of orphan, ultra-orphan (very rare)

and end of life drugs for patients. To date, around £200 million has been made available to Boards in Scotland through the New Medicines Fund which is a significant contribution to achieving value based pricing itself.

The Committee also asked for my view on what should happen if the outcome, once assessed, differ from the original claims by the company. As you will know, there is a greater interest from the pharmaceutical industry to explore outcomes-based pricing and commercial agreements and we are actively considering how the VPAS might provide new opportunities in relation to innovative and flexible approaches to pricing. Critical to the delivery of novel pricing approaches will be the NHS capability to collect outcome data, which is why our strategic approach to data collection and the interdependency with the Digital Health and Care Strategy is important. I would imagine that in the event that the outcomes are different there would be the opportunity to consider a number of options, including whether to reconsider the reimbursement price, review and/or its place in any prescribing guidance.

As part of our discussions the Committee asked about the dispensing of medicines and care homes and the need for care to pay to hold Home Office licences to hold stock. The Scottish Government does not think it would be appropriate for care homes to have a dispensation from the current requirement for a Home Office license if they are holding controlled drugs as stock. As care homes are in essence the residents own home, residents should have their own medicines prescribed and dispensed as per their own personal requirements. Controlled drugs would still require to be individually prescribed regardless of the model.

Hospices are exempt by the Home Office to pay for a licence due to fact they are primarily funded through voluntary contributions or charity. Under existing rules, private care homes would be required to apply and fund any licence and it would be for each care home to make an appropriate argument to the Home Office to have an exemption applied.

If care homes were able to stock ward controlled drugs they would be subject to the same regulatory requirements such as community pharmacies, community hospitals and hospices and would need to be tightly regulated. Stock control and monitoring in line with the controlled drug regulations would potentially be onerous for care home staff or a visiting pharmacy service.

However, there are other factors, specific to care homes, that would require appropriate governance is in place to reduce the risk of controlled drug errors/diversion. These are:

- Not all care homes have a registered nurse
- Significant workforce challenges in the Social Care sector
- Potential for increased risk in drug errors in care home staff selecting medicines from stock rather than individual supplies.

Granting all care homes a controlled drugs licence would be a significant change to current practice and potentially significant challenges for owners in terms of adapting their facilities to meet controlled drug regulations, the appropriate governance to ensure risk around the diversion of controlled drugs is mitigated.

One of our five Pharmacy Clinical Leadership Fellows is undertaking work on improving the pharmaceutical care of residents in care homes, in line with Achieving Excellence in Pharmaceutical Care. Along with taking forward examples of best practice of pharmaceutical care in care homes for national implementation they are exploring:

- The development of a care home specialist interest group.
- The greater use of electronic Medicine Administration Record (eMAR) in a care homes.
- The use the Medicines: Care and Review (M:CR) service in care home residents.
- Examine the use of a palliative care assessment tool in care homes, and
- Address the issue of improving waste reduction of medicines in care homes.

I trust this information is helpful for the Committee and would be happy to provide any additional information if required.

Yours sincerely,

Dr Rose Marie Parr
Chief Pharmaceutical Officer and Deputy Director,
Pharmacy and Medicines Division