English CCG formularies
Resources & priorities

Cogora

Report based on results previously presented at the ISPOR 19th Annual European Congress in Vienna:
Murphy, E (2016) English CCG formularies: resources and priorities.

Introduction

Clinical commissioning groups (CCGs) are responsible for regional healthcare provision in England[1]. As part of this, the CCG formulary group develops and maintains local formularies and decides if drugs that have not yet undergone a technology appraisal by the UK's National Institute for Health and Care Excellence (NICE) but are considered of importance to the local population should be included in the formulary. To aid decision-making, NICE has developed guidelines for how CCGs should manage their formularies[2]. These recommend that the CCG formulary group involves locally relevant stakeholders in decisions, including clinical networks, patient groups, local people and communities as well as relevant manufacturers. If local evidence synthesis and critical appraisals are conducted, the guidelines further recommend that CCGs ensure the availability of individuals with the necessary specialist skills, such as literature searching, appraising data, interpreting data and contextualizing evidence.

We conducted an online survey with invited commissioners to understand:

- How local formulary groups currently work and the extent to which they follow NICE guidelines for managing local formularies
- The data that are considered and prioritised when making local formulary decisions

Conclusions

- **There is demand for CCG-specific health economic data.** The majority of CCGs require both cost-effectiveness (CE) and budget impact (BI) estimates during formulary decisions. Most commonly, they require BI estimates to be based on CCG-specific data, highlighting the importance of ensuring that formulary submissions are developed to meet local, rather than national, needs

- **CCGs require support in developing in-house expertise.** Despite the importance of health-economic data during decision-making, two-fifths of surveyed CCGs (42%) do not conduct their own CE or BI analyses and only one-quarter (25%) have at least one person with formal training in how to appraise such data on their local formulary group. To ensure funding decisions are made to the highest standards, there may be a need to allocate time and resources to develop in-house expertise in the critical appraisal of data used to underpin formulary submissions in some CCGs

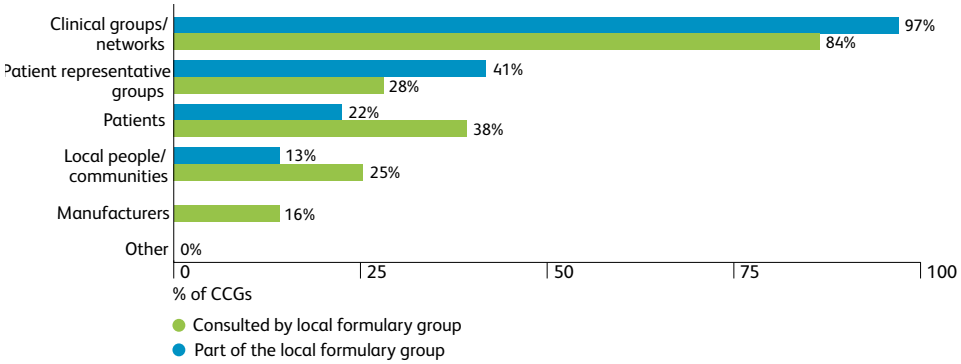
- **Patients are underrepresented in formulary decision-making.** Despite recommendations to involve them when developing and reviewing local formularies, patients and patient representative groups are only included or consulted by between one-fifth and two-fifths (22% to 41%) of surveyed CCGs. This could mean that important user views are missed during decision-making

Results

Stakeholders involved in formulary decisions

Clinical groups or networks are represented on, or consulted by, the formulary group in nearly all CCGs surveyed (97% and 84%, respectively) (Fig. 1). Conversely, only between one-fifth and two-fifths (22% to 41%) of CCGs surveyed either include patient representative groups or patients on their formulary groups, or consult them during formulary decisions. There is also low representation of local people and communities (members of, or consulted by, 13% and 25% of CCGs surveyed, respectively). Few CCGs surveyed consult manufacturers during formulary decision-making (16%).

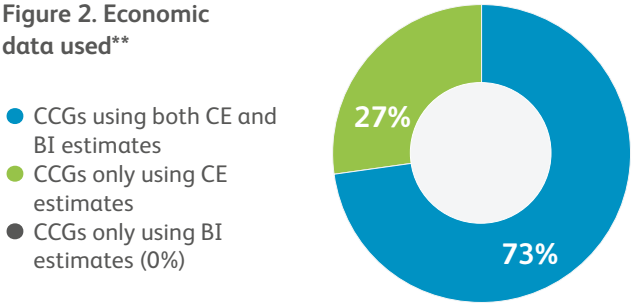
Figure 1. Stakeholder involvement*



Data considered when making local formulary decisions

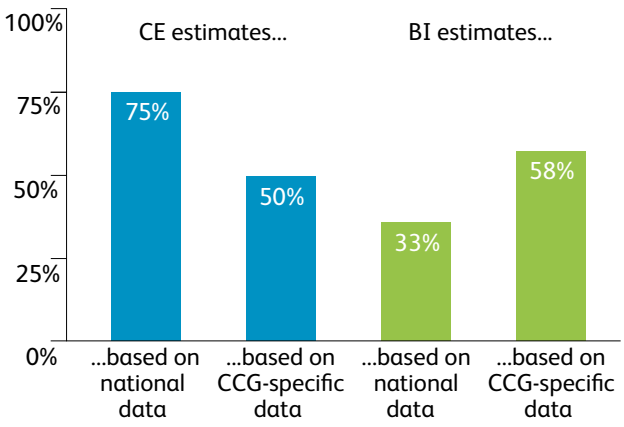
All respondents that are standing members of their local formulary group report using either CE or BI estimates when making formulary decisions. Approximately three-quarters of CCGs (73%) use both CE and BI estimates while approximately one-quarter (27%) only use CE estimates (Fig. 2).

Figure 2. Economic data used**



CCGs are more likely to require CE estimates that are based on national data than CE estimates that are based on CCG-specific data (75% versus 50% of CCGs surveyed) when making decisions on which drugs to include in their local formulary (Figure 3). A reverse trend was seen for BI estimates. When considering BI data, CCGs are more likely to require estimates that are based on CCG-specific (58%) rather than national (33%) data.

Figure 3. Use of national versus regional data**



Data from the whole sample were included (n=32)

***Only data from respondents who are standing members of the formulary group were included (n=12)*

Analyses & expertise within CCGs

Economic data

All CCGs surveyed consider economic data during formulary decisions (Fig. 2) but only three-fifths (58%) conduct in-house CE and BI analyses (Fig. 4A). Instead, CCGs likely rely heavily on the health economic data included in the prepared formulary submissions with only half (50%) conducting in-house critical appraisals of the health economic data presented therein (Fig. 4A).

Notably, only one-quarter (25%) of respondents report that a member of their local formulary group has received formal training (defined as training delivered during a university course or a non-university course/workshop delivered by an expert in the area) in how to critically appraise health economic data (Fig. 4B).

Clinical data

Three-quarters of CCGs (75%) conduct an in-house critical appraisal of clinical data presented in formulary submissions (Fig. 4A) and almost all (83%) of the CCGs surveyed have at least one member on their formulary group who has received formal training in how to conduct such appraisals (Fig. 4B).

Evidence gathering

While few CCGs conduct evidence synthesis in the form of e.g. systematic reviews (17%), over half (67%) have a member on their formulary group who has received formal training in how to perform and appraise literature searches and systematic reviews (Fig. 4B).

Figure 4A. Analyses conducted within CCG**

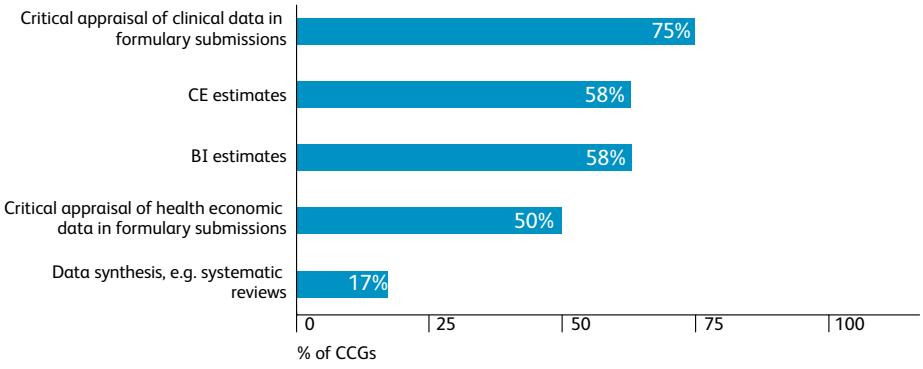
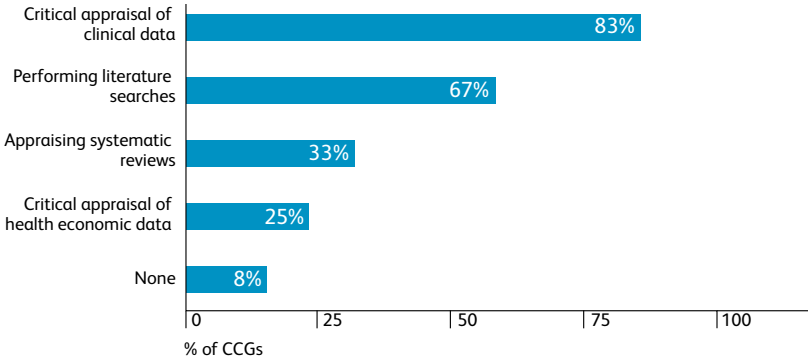


Figure 4B. Expertise within CCG**



***Only data from respondents who are standing members of the formulary group were included (n=12)*

Methods

Commissioners who had registered with *The Commissioning Review* and *Pulse* and who had a validated professional email address were invited to an online survey between June and October 2016.

Sample

Thirty-nine respondents completed the survey. Three were removed as they had recently retired from their commissioner role. To avoid double-counting, four respondents were removed as more than one respondent from the same CCG had completed the survey. When removing duplicate entries from one CCG, priority was given to (i) respondents who were standing members of the local formulary group and (ii) the first respondent to complete the survey, in that order. This left a total of 32 respondents. The final sample included commissioners from 30 CCGs (14% of all English CCGs) and two respondents who did not state which CCG they work in. Of the final sample, 12 commissioners were standing members of their formulary group.

References

1. NHS Commissioning Board. 2013. *The functions of clinical commissioning groups.* Available at: https://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf (last accessed on 2 Oct 2016).

2. NICE. 2014. *Developing and updating local formularies*. Medicines Practice Guideline 1. London: NICE.

For further information on the report or our services please contact ellenmurphy@cogora.com

Cogora
T +44 (0)20 7214 0500
F +44 (0)20 7214 0501
E ellenmurphy@cogora.com
W cogora.com

Cogora