Agenda item: 11

Report title: Individual GP practice 'Fair Share' Budget Setting for Primary Care Prescribing

1. Background

Prior to merging as BNSSG CCG the three separate CCG Medicines Optimisation Teams had differing budget setting methods for the GP practices in relation to their primary care prescribing spend. For 18/19 each practice was given their outturn for 17/18 as their indicative budget in order to work towards making savings on this as laid out in the Prescribing Quality Scheme. This was the first stage in aligning the previous CCG's individual work where there had been differences in whether financial budget achievement was linked to the Prescribing Quality Scheme.

During the past few months the Medicines Optimisation Team have been working closely with CCG Business Intelligence Colleagues to design 'fair share' budget setting methodology for the GP practices for their Primary Care Prescribing spend.

This has been discussed at a budget setting working group, at the three individual ALG's and also presented at the forums for comment and feedback.

There has also been review of other CCG Medicines Optimisation Team approaches to practice budget setting but this concluded that while many options are available, designing our own bespoke model would ensure engagement from our members.

It is important that we are able to set a fair share budget for individual practices which has agreement from all stakeholders in order to ensure buy in and to enable practices to feel a greater responsibility to prescribe within their allocation. This will also highlight practices who may be spending more in particular areas than their 'allocation' which has not been possible in the past due to budget being based on historical spend, enabling the medicines optimisation team to identify potentially unwarranted variation in prescribing.

This paper is being bought to PCCC for agreement to proceed with a fair shared budget setting for the primary care prescribing budgets at practice level for 19/20. It is also to obtain agreement that the preferred methodology (these are discussed later in the paper) to calculate the budgets is the most appropriate for BNSSG practices.

2. The Methodology

The Medicines Optimisation Team worked with GP and Practice Manager representation, along with the CCG Business Intelligence Team to develop five 'fair share' options for consideration.

Appendix 1 shows the full list of components that were considered in each of the 5 different potential methods. All calculations during the work up of these methods have used 17/18 data so this will require updating prior to final budgets being set. Dressings were excluded from the calculation and added separately due to the current different models of ordering in the different areas.

A brief summary of each option is below:
See appendix 1 for a more detailed explanation of these options and the components included in them.

Method/ Option	Components
1. List Size	Based on raw list size
2. Carr-Hill	Based on the Carr-Hill allocation methodology
3. ASTRO PU	Takes into account only age and sex of practice population
4. NHS England Prescribing Need	Uses the Prescribing Need Value allocation included as technical guidance in the overall NHSE CCG allocations for 19/20.
5. Modified NHSE formula	This uses a modified version of Method 4 the NHSE Prescribing Need allocation. Prior to the calculation, practice level prescribing spend from 17/18 on high cost drugs and key disease areas (COPD, Asthma, Diabetes and Atrial Fibrillation (NOACS)) was removed. The remainder was allocated using the NHSE prescribing need allocation. High cost drug spend was then added back into each practice. Finally spend on disease prevalence of the 4 key areas was added to each practice based on most recent QOF prevalence data.

It has been agreed following presentation at the GP forums that Method 5 considers many factors and takes into account components which are agreed as important.

Method 1 takes into account no weighting of patients with regards to demographics and disease prevalence, treating each patient as the same and so was discounted. Method 2; Carr Hill methodology is often heavily criticised as out of date and contains measured not relevant to prescribing and therefore was agreed this was not appropriate to use. Method 3 using only ASTRO PU covers only the age and sex of the practice population and so again as with method 1 was discounted as did not have enough patient factors taken into account.

As highlighted above, method 5 uses the NHSE CCG allocation method (method 4) which has a prescribing component at GP level included in it. Following our meetings to discuss the methods, it was felt that we should take into account High Cost Drug Spend and disease prevalence for each practice. It was agreed therefore to modify Method 4 to take into account individual High Cost Drug Spend (as this tends to be unavoidable and often driven by specialist prescribing) as well as disease prevalence and spend in four key clinical areas. These areas are Diabetes, COPD, Asthma and AF (prescribing of NOACs). This CCG spend for 18/19 (on high cost drugs and the 4 clinical areas) was taken out of the whole budget, with the remainder being allocated using Method 4. Once this was allocated, the high cost drug spend was added back in along with the spend on the four clinical areas based on the most recent QOF data.

Appendix 2 is a comparison box plot which shows the impact of the different methodologies on the percentage allocation for each practice for 19/20 compared to each practices percentage spend of the overall spends for the financial year 17/18. It highlights the relative percentage change in budget allocation for each method and shows that for the preferred method 5 there is the narrowest of plots which would indicate the least number of outliers when comparing their allocation to their 17/18 outturn.

3. Setting the budgets for financial year 19/20

It is clear from the methodology that there are practices who are spending considerably less than their potential allocation and some who are spending more. It is important to work towards achieving these budgets in a realistic time frame in order to ensure that it does not lead to disengagement from practices, particularly for those practices currently spending more than their allocation. At the same time, it is important to support practices that are currently spending less than their allocated budget to ensure they continue to do so. They must also be looked to for any areas of good practice that may be shared across the CCG

In order for practices to reach their new allocated budget we would recommend a phased approach over 2 years to work with the practice to reduce their to spend to the ‘fair shares’ allocated amount.

This can be achieved by applying a ‘cap’ to the reduction in the percentage spend required over the 2 years. E.g. the allocated budget suggests a practice should be spending 15% less than their outturn. This would be phased over the two years by asking them to reduce for example by 5% and 5% each year and reaching budget in the third year.

For a practice where their budget allocation is calculated as higher than their 18/19 outturn, they would be encouraged to maintain the same level of prescribing unless there is a clinical reason not to or a change in circumstances and so their budget would be capped at 18/19 outturn. This is important as part of the 19/20 prescribing scheme will be set based on achieving financial balance in order to support the CCG in achieving their financial control total.

4. Financial resource implications

The methodology agreed considers many factors as detailed in Appendix 1 and determines the percentage of the overall Primary Care Prescribing budget which should be attributed to each practice. Currently the Medicines Optimisation Team has not been notified of the overall Primary Care Prescribing Budget for 19/20. We have been asking members to agree that the methodology used was 'fair'.

5. Legal implications

The budget setting links to overall CCG financial position and priorities.

6. Risk implications

There is a risk to the overall CCG Control Total, if the Primary Care Prescribing spend is not monitored and controlled by the Medicines Optimisation Team. Budget setting will enable the team to work with practices to identify areas of unwarranted variation in prescribing spend for particular areas in relation to what is considered a 'fair' budget for their practice population.

There is a risk of non-engagement from practices not in agreement with these methods although feedback has been sought throughout the design process.

7. Implications for health inequalities

All work undertaken or directed by the Medicines Optimisation Team will have any implications for health inequalities considered.

8. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

All work undertaken or directed by the Medicines Optimisation Team will have any implications for equalities considered.

9. Consultation and Communication including Public Involvement

A working group initially met to discuss the important factors that should be considered during the design of these methods. This working group included key primary care (GPs and Practice Manager) stakeholders. This working group discussed the factors considered important and agreed that High Cost drugs and disease prevalence should be included in the calculation. Once the methods had been developed, these were presented at the three Area Leadership Groups (ALG) for feedback and then to the GP forums. At the ALG meetings it was agreed that this method was fair and there was discussion around 'high cost patients' and how these are considered. It is hard to factor these all into the method and would hope that many of these will fit within the 'high cost drug' factor. At GP forums there was general agreement that Method 5 seemed a fair method even though it was clear to some practices that their allocation of the overall budget will be lower than they spent in 17/18. It was discussed how the Medicines Optimisation team will be working with practices to support them through this change and work with them to

identify areas of potential cost savings in order to work towards prescribing within their allocated budget.

10. Recommendations

It is recommended that:

- There is agreement to proceed with calculating Primary Care Prescribing Indicative budgets at practice level using Method 5 for the financial year 19/20.
- There is a phased approach over 2 years to get all practices to spending within their allocated budget

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Appendix 1:

Summary of the components included in each of the models explored

	Method	Components
1	**List size**	Based on raw list size (registered patients as of current NHAIS data)
2	**Carr-Hill**	Weights based on age/sex, list turnover, standardised mortality ratio, a standardised measure of patients living with long term illnesses, number of patients in nursing and residential homes, and also some geographic factors (rurality and market forces). Coefficients estimated from national data which are intended to reflect the marginal costs of running a practice associated with each of these factors are applied to the practice-level measures. Note that this formula intentionally includes factors which are not related to prescribing need.
3	**ASTRO PU**	Splits population into age/sex bands, multiplies the number of patients in each band by coefficients derived from national data which represent the marginal prescribing costs associated with each group.
4	**NHS England Prescribing Need**	Combines ASTRO PU with "additional need" measures based on the proportion of patients over 75 who are over 85, proportions of patients over 70 who receive disability living allowance, standardised mortality ratio, a measure of whether practice has a particularly high number of patients aged 20-24 (based on national ranking), the overall inferred Index of Multiple Deprivation score for the practice, the age/sex standardised proportion of the population who have "activity limiting health conditions", the proportion of the population living in social housing, and a measure of ethnic mix. Each of these measures (derived nationally) is multiplied by a coefficient derived from historic national data which estimates the marginal prescribing cost of each

		of the factors. The raw list size is then first adjusted using the ASTRO weighting, and the resulting weighted population is then adjusted again using a factor calculated from the "additional needs" weightings and then normalised, so that the overall population national population matches the actual national population.
5	**Modified NHSE**	Takes the actual spend on high cost and amber drugs (excluding NOACs) for 2017/18, and an inferred spend on for key diseases (based on prevalence per practice, and average cost per prevalence calculated from 2017/18 ePACT data). Sums this across all practices. Removes this sum from the total available budget. Shares out what is left using the NHSE Prescribing Need. Then adds the high cost and key disease spends for each practice.

Appendix 2:

A comparison box plot showing percentage change in budget allocation compared to financial spend (percentage of the overall CCG spend) for 17/18:

It highlights the relative percentage change in budget allocation for each method and shows that for the preferred method 5 there is the narrowest of plots which would indicate the least number of outliers when comparing their allocation to their 17/18 outturn (e.g. this has the narrowest differences in terms of practices getting more/less of a percentage of the overall budget compared to what they spent in 17/18).