All WALES PRESCRIBING INCENTIVE SCHEME

DEVELOPED BY THE ALL WALES PRESCRIBING ADVISORY GROUP (AWPAG) A SUB-GROUP OF THE ALL WALES MEDICINES STRATEGY GROUP (AWMSG)

AWPAG Working Group Members:

Dr Jeremy Black (General Practitioner, Cardiff LHB & Lead)
Mrs Nicola John (AWPAG Vice Chair, NPHS)
Dr Mark Daniels (General Practitioner, Neath/Port Talbot LHB)
Mr William Duffield (Pharmacy Advisor, Wrexham LHB)
Mrs Delyth Simons (Pharmacy Advisor, Pembrokeshire LHB)
Mrs Judith Vincent (Pharmacy Advisor, Swansea LHB)
Mr Jamie Hayes (Director, WMP & WeMeReC)
Mrs Karen Samuels (Programme Manager, WMP)

Purpose:

The paper contains:

1. A proposed National Prescribing Incentive Scheme (NPIS) with supporting documentation

2. Recommendations for its successful implementation and maintenance

Action for AWMSG:

AWMSG is asked to recommend to Welsh Assembly Government that:

There should be an All Wales Prescribing Incentive Scheme of the nature detailed in this paper in order to promote quality and cost-effective prescribing in Wales.

This scheme will be most effective and will allow cross-LHB comparison only if it is made compulsory. However, AWPAG have expressed their grave concern over the lack of robust advice to Local Health Boards (LHBs) on a budget setting formula and would recommend that, until such advice is in place, the scheme be optional.

Background:

The All Wales Prescribing Advisory Group has considered at its October 2003[1, 2] and January 2004[3] meetings both the need for Prescribing Incentive Schemes and the wide variety of such schemes in Wales at present. Whilst almost all LHBs have devised or continued from the Health Authority period a prescribing scheme, there has been little if any commonality between them and they have had variable degrees of success in influencing prescribers. It was decided to set up an AWPAG sub-group to devise a common structure for an All Wales Prescribing Incentive Scheme. The proposed structure was considered at the AWPAG April 2004 meeting[4] and accepted. The sub-group agreed to progress the outline proposals to detailed proposals for presentation to AWMSG in December 2004.

[1]AWPAG Oct 2003 minutes (item 4)
http://www.wales.nhs.uk/sites/documents/371/Final%20%20meeting%20notes%20Oct03%20Vesion%202%2Epdf

[2] Presentation AWPAG Oct 2003 (Routledge P)
http://www.wales.nhs.uk/sites/documents/371/PRoutledgePrescribing%20incentive%20schemes%20AWPAG%2Epdf

[3] AWPAG Jan 2004 minutes (item 9)
http://www.wales.nhs.uk/sites/documents/371/AWPAG%20Minutes%20030204%2Epdf

[4] AWPAG Apr 2004 minutes (item 7)
http://www.wales.nhs.uk/sites/documents/371/Final%20minutes%20April04%2Epdf

Consideration:

"*Incentive schemes are the main mechanism by which the goals of the PCT are made meaningful at practice level." (Audit Commission Report on Primary Care Prescribing*[1])

The need for Prescribing Incentive Schemes is considered within the National Audit Commission (NAC) report. Apart from the obvious difference that Prescribing Incentive Schemes (PIS) are mandatory in England but not in Wales, the report can be applied with little alteration as the pressures both on prescribers and PCTs/LHBs are extremely similar. The report favours use of incentive schemes as part of a four-pronged approach to influencing prescribers.

"*PCTs must adopt a robust and proactive stance in promoting their strategic goals for prescribing. A number of components are needed to achieve this:*

- *strong leadership with consistent messages from the PCT*
- *an effective GP prescribing lead*
- *open sharing of performance data; and*
- *a well-designed incentive scheme.*

(Audit Commission Report on Primary Care Prescribing[1])

Whilst it was outside the scope of this group to consider the other approaches in detail, the consensus view was that a National Incentive Scheme without the other elements proposed would be much less effective.

There is a need for clear guidance to LHBs regarding:

1. the need and role of a GP prescribing lead and

2. the requirement for open (ie non-anonymised) sharing of performance data (including prescribing data).

Whilst the first item is being addressed by AWPAG[2], it was felt that a lead from WAG regarding the second could help to accelerate the process in those areas where open sharing of performance data has not been the norm.

In designing a National Prescribing Incentive Scheme, the group considered three options:

a) A common scheme
b) A common structure
c) A common structure with some common elements

The common scheme was rejected as it did not allow any flexibility to address issues at a local level. This was considered vital by all LHB pharmacy advisers and also strongly encouraged by the National Audit Commission. A common structure alone would fail to allow any nationally determined priorities to be addressed or allow cross LHB comparison in terms of indicator or audit performance unless by chance all 22 LHBs adopted the same indicators or audits. The common structure with some common elements was felt to achieve a compromise between allowing local flexibility yet maintaining a scheme recognisably similar between LHBs and allowing some degree of cross comparison.

The common structure (see Appendix 1)

The structure consists of two equally-weighted parts:

1. Indicators (worth 50% of total remuneration)
2. Learning Portfolio (worth 50% of total remuneration)

1. Indicators

These refer to calculations performed upon prescribing data for individual practices. They are widely used and most current prescribing schemes incorporate several. They have the following advantages:

a) They can be calculated automatically and within minimal effort from prescribing data collected by Health Solutions Wales

b) They can be produced frequently and with a minimal (three month) time lag

c) They can be used to measure prescribing cost and frequency of individual drugs or drug classes

d) They lend themselves to measuring cost or cost-effectiveness issues

They also have disadvantages:

a) They do not easily measure *appropriateness of prescribing* as the drug use is not attributed to particular disease states or clinical indications

b) The weighting mechanisms (to allow for differences in practice population drug requirements) are imperfect

Within the common structure two groups are used:

National Indicators (previously known as high-level indicators)

These are indicators to be produced and reviewed by AWPAG on a yearly basis. The 2005/6 National Indicators[3,4] form part of the LHB SAFF requirement and are summarised below:

a) Generic prescribing rate
b) Inappropriate Generic prescribing rate
c) Hypnotic/Anxiolytic prescribing rate
d) Co-proxamol* prescribing costs
e) NSAID prescribing rate

They are considered in more detail in appendix one.
* now subject to advice from MHRA

LHB Indicators

These indicators (a minimum of five to be used) are to address local prescribing priorities. The nature of the indicators and the scoring mechanism are to be determined at LHB level.

2. Audit

Audit allows the connection between medicine use and the appropriateness of that use to be measured (e.g percentage of patients receiving a lipid-lowering agent where usage reflects national guidelines, percentage of patients receiving clopidogrel according to licence and national guidelines). However as remuneration will follow the production of an audit(s) (rather than its results), the weighting for this part of the scheme is lower than might otherwise be expected. A National Audit allows for the first time the implementation of nationally produced prescribing guidelines to be assessed.

The National Audit will be produced by AWPAG and will run for a two-year period. If LHBs have the need and resources to produce audits of their own, these can be run in parallel. If not, then the 10% of the scheme set aside for this is to be attributed to the National Audit.

3. Education/Training

Educating prescribers has always formed part of the implementation of prescribing incentive schemes, but usually in an informal sense (practice visits and/or newsletters from the prescribing advisors). A few innovative LHBs have incorporated education or training into the fabric of their schemes to help ensure uptake by prescribers. Although the new contract does reward practices that meet with their LHB prescribing advisers, the rewards are relatively small (£300 in 2004/5, rising to £500 in 2005/6 for an average practice).

This element of the National Prescribing Incentive Scheme will improve the ability of LHB pharmacy advisors to compete with messages that prescribers may receive from drug company advertising and representatives, whose messages may not always be in line with LHB advice.

The national element will be provided by the Welsh Medicines Resource Centre (WeMeReC), who will produce educational bulletins with individual feedback to prescribers. With the advent of electronic distribution, WeMeReC plan to produce more frequent bulletins which are more responsive to current events (e.g a new “ground-breaking” study, a new licence for individual drugs) allowing prescribers to receive a more rounded view of the evidence base than may be provided by industry representatives alone. To qualify for the

remuneration, *all* prescribers in the practice will be required to participate in the Study Program for the year. This is the first time that a Prescribing Incentive Scheme has required individual practitioners to partake in continuing therapeutics education

The local element allows LHBs to provide an incentive for practitioners or Practice Prescribing Leads to attend LHB organised meetings which will help to overcome the loss of the "PGEA-approval" carrot. LHBs need to be aware that rapid education of practitioners or practice prescribing leads can help prevent the unplanned uptake of new, comparatively unproven and relatively expensive medications, and avoid the need to then alter established prescribing habits at a later point in time (see appendix 2).

Weighting (see Appendix 1)

Cost-effectiveness is a vital part of prescribing and recognised by the General Practitioners Committee (GPC) of the BMA and the Royal College of General Practitioners

"The excellent GP…..
Takes resources into account when choosing between treatments of similar effectiveness"

"Good Medical Practice" GPC/RCGP

However, the scheme has been carefully tailored so that it is NOT simply an exercise in cost-reduction. It is an attempt to incentivise general practitioners to improve the *quality* of their prescribing as well as the cost-effectiveness.

- Of the five National Indicators for 2005/6, four are measures of safer prescribing, which will help reduce the morbidity associated with medicines use in Wales.

- The National Audit will help to ensure that patients that receive the drug(s) which is(are) the subject of the audit are receiving them appropriately, in the right dose and for the correct period of time. The Audit can be combined with National Guidelines to enhance the effectiveness of the latter.

- The proposed WeMeReC study program is a unique opportunity to engage all general practitioner principals in Wales and help ensure they remain up-to-date and abreast of changes in prescribing recommendations from a recognised authority. It will help to balance the influence of the pharmaceutical industry representative and also provide the opportunity for the first time to examine the thought processes behind prescribers' actions and beliefs regarding certain therapeutic areas. This may be a valuable resource upon which future educative programs can be built and audited.

- LHBs will be encouraged and able to reward practitioners for engaging in learning activities which reflect the LHB's prescribing strategy.

It is difficult to perform a cost-benefit analysis upon this aspect of the scheme as nothing akin to it has been attempted before. The fact that the scheme is quality-heavy in its structure is likely to make it more acceptable to practitioners, particularly as it will form a part of the practitioners learning portfolio and help in both appraisal and revalidation. The potential to earn for the practice significant amounts of money to be used for the benefit of its patients is the necessary incentive to help ensure that this initiative is not lost in the "noise" of the GMS contract.

Remuneration

This is dealt with in detail in Appendix 3. It is summarised below.

There are three fundamental issues:

1. Ensuring that the monies available are sufficiently attractive to motivate prescribers to change

2. Ensuring that obtaining the monies is neither too hard, nor too easy.

3. Ensuring that any monies dispensed are spent appropriately

With regard to the first, it is proposed that underspending practices retain up to 25% of their prescribing underspend, modified by their score on the National Prescribing Incentive Scheme (NPIS) – if they score 50% on the scheme then this percentage is applied to their potential reward.

Underspending practices are thus rewarded but the point was made by the NAC that for incentive schemes to work, simply rewarding under-spending practices is counter-productive.

"In the current climate of high growth in drugs a simple requirement to stay within budget or underspend by less than the previous year is extremely difficult for most practices to achieve. However, this is how the majority of PCTs (75 per cent in our survey) have interpreted the DoH guidance. If this definition is used, forecast overspends can make the incentive scheme meaningless within weeks of the start of the year. This has, in some PCTs, led to the virtual abandonment of the scheme. As a result, the non-financial targets are not achieved."

NAC Primary Care Prescribing 2003

To engage practices which may not reach an under-spend position in the first year of the scheme, it is proposed that a payment be made to *all* practices that satisfy the LHB pharmacy adviser that they are engaging with the LHB prescribing policies and moving towards an improvement in prescribing quality and ideally (though not compulsorily – see NAC above) a reduction in percentage overspend.

This payment will be based on a sum modified by the practice list size and their NPIS score. A sum of £500 per 1000 patients is proposed, which is then multiplied by their NPIS score percentage to obtain the payment.

Production and management of the National Prescribing Incentive Scheme

Any monies paid to a practice are to be reinvested in patient care, with the spend agreed by the LHB. Thus the funds are not paid directly to GPs and as such are non-super-annuable.

Ownership of the scheme rests with the AWPAG and the production and maintenance of the scheme is achieved through a working sub-group of AWPAG. This group should contain:

1. Chair/Vice Chair of AWPAG
2. Three General Practitioners from the regional sub-groups
3. Three primary care pharmacists from the regional sub-groups
4. A NPHS representative
5. An LHB financial representative (finance manager)
6. WeMeReC representative

The General Practitioners should have an active interest in therapeutics and be involved in their local LHB prescribing sub-group.

The scheme will be reviewed yearly and a report made to AWMSG by December of the year preceding the year in which any modifications are to take place.

It must be recognised that the maintenance of this scheme and the production of suitable educational materials for incorporation in the scheme will have resource implications for both AWPAG and WeMeReC.

[1] **Primary Care Prescribing** (2003), National Audit Commission
http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/4BB73230-58A6-11d7-B28A-0060085F8572/Prescribing-bulletin_web.pdf

[2] AWPAG minutes April 2004 (item 14)
http://www.wales.nhs.uk/sites/documents/371/Final%20minutes%20April04%2Epdf

[3] AWMSG Enclosure 13 June 04
http://www.wales.nhs.uk/sites/documents/371/Enclosure%2013%20National%20Indicators%200506%2Epdf

[4] AWMSG Minutes June 2004(item 18)
http://www.wales.nhs.uk/sites/documents/371/Final%20Minutes%20June%202004%2Epdf

This information should be considered alongside any relevant clinical advice issued by National Advisory bodies, eg MHRA. Future versions will reflect these directives.