Future Focused Finance CCG Network – Sharing Good Practice in CCGs

Vale of York CCG – Prescribing Indicative Budgets

Vale of York CCG has designed and implemented a prescribing gain share scheme with general practice that has reduced prescribing costs by £3.82m when compared to the 2016-17 baselines.

A summary of the scheme

The CCG worked with 3 local alliances to optimise the efficiency of GP practice prescribing.

Each alliance was set an indicative budget based on historic spend. Any savings made against this budget were shared with the alliance based on a stepped gain share model, to be reinvested in primary care.

The initial project ran from July 2017 to March 2019. In 2018-19 savings of £0.89m were made, with £0.30m paid to alliances. In 2019-20 savings increased to £3.82m, of which £0.96m is being paid to alliances. This means that in total over the lift of the PIB1 project £1.25m has been reinvested into primary care.

For context, Vale of York CCG has an estimated population of 361,000 and total in-year allocation of £488.7m (2019-20). The CCG's primary care prescribing budget is in the region of £48m. Historically, the CCG has a low spend per ASTRO-PU – the lowest in Yorkshire and Humber and third lowest in the North – so additional savings have been difficult to find.

Implementing the scheme

Alliances were given freedom to identify their own areas to target for savings, based on their current spend and characteristics of their practice populations. Examples of areas that alliances focused on were red and black drugs, self-care items, and switches relating to specific drugs.

A condition of the gain share arrangement was that funds were reinvested in primary care. The first year funding was generally used to further develop the indicative budgets scheme by funding staff backfill and employing additional medicines management staff. A wider range of schemes are being considered for reinvestment of 2019-20 funding, including schemes to support out of hospital care and reduce unplanned admissions.

10% of alliance savings were subject to achieving 10 quality indicators, which were set by the CCG's medicines management team. This helped to ensure that prescribing remained of a high clinical quality. At the end of each contract year, for each quality indicator achieved 1% of alliance savings were released.

The CCG obtained legal support to write a Memorandum of Understanding (MoU) for the scheme which outlined the arrangements and requirements of the CCG and alliances, including reporting requirements and a dispute resolution process.

The MoU made it clear that the CCG would continue to hold and retain statutory responsibility for the prescribing budget including accountability for overspends and underspends and ensuring the most clinically appropriate, cost-effective and safe use of medicines across the locality.

The scheme was always managed at alliance level rather than individual practices to offset variation, encourage collaborative working, support effective reinvestment of funds at scale and simplify reporting and payment.

Financial arrangements

Key to the scheme was the gain share model that was established to incentivise alliances to maximise efficiency of their prescribing.

Alliance indicative budgets were based on 2016-17 actual spend and were inflated each year in line with planning assumptions.

Two trigger points were then set, based on spend per prescribing weighted head. The first was average spend per weighted head across the whole of the CCG. The second was the lowest alliances spend per weighted head – this was called the benchmark. The share of savings was then based on the following stepped model –

- Where spend was higher than the CCG average spend per weighted head, alliances were paid 25% of any savings made against their indicative budget.
- Where spend was between CCG average and benchmark spend per head, alliances were paid 50% of any savings made against their indicative budget.
- Where spend was lower than the benchmark spend per head, alliances were paid 75% of any savings made against their indicative budget.

This model recognised that alliances with a low spend per weighted head would find it more difficult to make savings as they had already achieved the easy wins – they were therefore rewarded with a higher share of savings.

Weighted population by alliance was based on the prescribing need element of the CCG allocation formula – the allocation technical guidance documentation provides this at

practice level. This was therefore a direct comparison with how funding for prescribing is determined at a national level.

A key factor was basing indicative budgets on historic actual spend, and trigger points on performance within the CCG – this meant that the standards that the alliances were being monitored against had been demonstrated as achievable.

Savings were calculated each quarter and paid on a cumulative basis. This meant that if an alliance overspent against their indicative budget in one quarter, this overspend would be netted off the next quarters savings and payment reduced accordingly.

No Cheaper Stock Obtainable (NCSO) became an issue in 2017-18, but the scheme had been set up so that indicative budget performance would include all under and overspends, whether they were due to alliance intervention or not. Therefore savings were lower than they would have been otherwise in 2017-18, but once the magnitude of NCSO lessened in 2018-19 the savings materially increased.

Going forward and lessons learned

The CCG are now developing the second iteration of the scheme, PIB2. This has been delayed slightly as it will be based around Primary Care Networks (PCNs) rather than alliances.

For PIB2 the CCG's medicines management team will take a more active role in determining areas of work for PCNs, in order to allow more effective targeting of areas of spend. This will also allow for more targeted monitoring of spend patterns and savings.

In PIB1 it was difficult to evidence whether savings were a result of alliance intervention or other factors. The MoU for PIB2 will include conditions around evidencing intervention on the areas of focus set by medicines management.

In the PIB2 scheme indicative budgets will be rebased every year, based on the previous year's spend plus uplift. Because PIB1 started part way through the 2017-18 financial year the indicative budget was set at the same level for 2017-18 and 2018-19 (with uplift in line with financial plan for year 2). This made monitoring of savings complicated and meant that alliances were effectively receiving payment against the previous financial year's savings.

Generally, PIB1 has been very well supported in the CCG and general practice and we hope to build on this success through PIB2 and working with Primary Care Networks.