NHS
Oxfordshire
Clinical Commissioning Group

Prescribing Incentive Scheme, 2019-2020

1.0 Background

Prescribing incentive schemes (PIS) are widely used by Clinical Commissioning Groups (CCGs) to incentivise and reward GPs to change practice and improve quality and cost effectiveness in prescribing. Oxfordshire CCG (OCCG) and its predecessor organisations have historically had an annual PIS in order to:

- increase value for money by improving the quality and cost effectiveness of use of health care resources by practices in the CCG and
- enable individual practices to realise benefits for patient care.

Achievement of the scheme provides practices with funds to directly benefit patients.

2.0 Conditions of participation in the scheme

2.1 There is no need to sign up to this scheme as there will be automatic inclusion and the OCCG Medicines Optimisation team will assess achievement of *all* practices. However, as in previous years, it is a requirement of the scheme for each practice to have a **prescribing meeting** with a CCG Prescribing Adviser to discuss prescribing priorities for the year. It is expected that all practice clinical staff and, ideally, local Community Pharmacists will be invited to this meeting.

2.2 Practices will also be required to continue to use **ScriptSwitch** and demonstrate its use through switches being made. This is a useful tool for making cost savings in prescribing as well as informing prescribers about quality issues.

3.0 Content and details of scheme

The scheme will run from 1st April 2019 to 31st March 2020 and will, again, concentrate on both cost effectiveness and quality and will comprise the following *four* elements (practices can work towards achieving all of them):

3.1 Element 1: Prescribing within budget allocation

This is critical to OCCG's financial position. The Medicines Optimisation team will produce a report containing data and links to tools which will highlight where savings can be made as well as support practices in identifying their own priorities. It is expected that these will also be discussed at a practice (or Primary Care Network (PCN)) prescribing meeting with an OCCG Prescribing Adviser. The Prescribing Dashboard (see below) will continue to be updated monthly to add further guidance on priorities and progress. **NB. payment for *any* element will only be triggered if the practice (or locality/primary care network) achieves the element 1 target**.

Target: each practice (or locality/primary care network) to spend no more than their allocated notional budget

3.2 Element 2: Quality project

Practices will be invited to take part in a project to use the PINCER risk stratification tool with the aim of reducing primary care appointments and hospital admissions in line with the NHS 10 year plan. PINCER is a proven IT-based intervention which has been shown to reduce clinically important

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medication errors in primary care using safety indicators. PINCER has been selected for national spread and adoption by all 15 Academic Health Science Networks (AHSN). Oxford AHSN is supporting the roll out of PINCER across Berkshire, Buckinghamshire and Oxfordshire.

The PINCER element of the PIS comprises several stages including running searches on GP clinical systems, uploading the anonymised data to an on-line platform, doing a root cause analysis to try and understand why the prescribing errors are occurring and developing and implementing an action plan to ensure that the errors do not occur in the future. Formal training sessions by Primis and facilitated by the AHSN will be available in the form of face to face meetings and webinars.

Practices will be required to run the searches and upload anonymised data to CHART on-line thereby allowing the results to be viewed by the Medicines Optimisation team. Practices will be required to select one safety indicator to work on from the PINCER query library which will have most benefit to their practice. It should be noted that the new GP GMS contract has included three areas for quality improvement in prescribing that practices will be required to work on ie:

1. NSAIDs & gastro protection
2. Lithium monitoring
3. Valproate use in pregnancy

As a result, *practices will not be able to review these areas as part of the PIS,* but will be encouraged to use the PINCER process to review them for the new contract instead. Therefore, it is felt that the PIS will complement the GMS contract but will not be a double payment.

Target: practices will be required to complete and submit a template to indicate their choice of safety indicator, provide a brief summary of their root cause analysis and action plan and describe what changes will be embedded into the practice system to avoid the errors recurring. Practices can demonstrate success by showing a reduction in patients at risk from prescribing errors by re-running the searches and uploading the results after a 6 month interval. However, a reduction in patients is not a prerequisite for payment.

3.3 Element 3: Antibacterials

In line with national policy and the new five year government action plan on antimicrobial resistance, we continue to promote good antimicrobial stewardship and, therefore, include this element in the PIS again with the aim of:

- improving the quality of antimicrobial prescribing through the promotion of self-care and management of minor infections, the use of back up prescriptions or 'no prescribing' strategies, and education for both patients and clinicians;
- reducing the incidence of Health Care Associated Infections (HCAIs) eg *C.difficile* by decreasing the prescribing of 'high risk', broad spectrum antibiotics eg cephalosporins, quinolones and co-amoxiclav.

Target: antimicrobial items per STAR PU to be below 0.52 (the OCCG average for Q3 and Q4 2016/17) PLUS high risk antimicrobial items (cephalosporins, quinolones and co-amoxiclav) as a % of all antimicrobial items to be < 10% (in line with the national target). This target will be measured using total figures for Q3 and Q4 (i.e. Oct 2019-Mar 2020)

3.4 Element 4: Cost saving audit

Practices will be asked to complete *one* of the following audits in order to release savings in a high cost area. This should help practices to also achieve Element 1 (above). The chosen project should involve at least 0.5% of total practice population (approx.) and the choice should be agreed with the CCG Medicines Optimisation team. In the event that no single audit provides sufficient patients to review, a practice will be invited to choose two audits. While a formal audit does not need submitting, practices are encouraged to keep a record of the work done for future reference.

a) Review prescribing of DPP4 inhibitors: all patients on a DPP4 inhibitor should be reviewed and if the DPP4 inhibitor is effective, switch to the most cost effective choice (alogliptin) using the approved switch protocol. If the patient's original DPP4i has not led to a reduction in HbA1c; review the patient's concordance and consider stopping the DPP4 inhibitor and/or adding a different class of medication.

Target: reduction in spend (compared with 2018-19) on DPP4i as shown by ePACT2 data

b) Review use of blood glucose test strips: review all prescribing of blood glucose test strips and, where appropriate, move patients onto meters using cost effective strips in line with most recent OCCG guidance (currently strips <£10 for 50, pending update to encourage use of strips <£6 for 50).

Target: reduction in spend (compared with 2018-19) on blood glucose test strips as shown by ePACT2 data

c) Review the use of infant formula and:
- ensure all infant formula prescribing falls within the OCCG Infant Formula Guidelines;
- ensure parents have advice on the reintroduction of cow's milk using the iMAP Milk Ladder so infants do not continue on prescribable infant formulas beyond the age of 18 months unless under the care of a paediatrician or paediatric dietitian;
- check the quantities of formulas prescribed to ensure ordering within the suggested amounts as per the OCCG Infant Formula Guidelines.

Target: reduction in spend (compared with 2018-19) on infant formula as shown by ePACT2 data.

4.0 Enablers

There are a number of resources and sources of support for practices:
- The CCG will provide all practices with a Prescribing Data Report identifying any areas where there may be potential savings or quality improvements.
- There will continue to be a dedicated scheme webpage providing resources; relevant protocols and audit templates, system searches, patient leaflets etc.
- The Prescribing Dashboard will be aligned to monitor 2019-20 scheme elements where appropriate, providing useful progress and benchmarking information.
- The Medicines Optimisation Team will support practice-based work on prescribing throughout the year. OCCG.medicines@nhs.net offers immediate access to Medicines Optimisation team advice.

5.0 Payment and funding options

5.1 Payment

Practices are encouraged to work towards achievement of all four elements, however payment will only be triggered if the practice (or locality/primary care network) achieves the Element 1 target at year end ie. keeps within budget. If successful, payment will be made for all other element targets which are met.

Element 1 (budget achievement) will be offered as an option at practice or locality/primary care network level. As in previous years, the latter would share the risk amongst the practices and encourage engagement across the locality/primary care network. In recognition of this, payment for

achieving Element 1 will be £0.15 per registered patient if done only at practice level or £0.30 per registered patient if done at locality/primary care network level. Localities/primary care networks are required to notify the CCG of their decision on this by 30th June 2019. The use of the PrescQIPP budget setting model offers greater confidence in accurate and fair budget allocation at practice level and should therefore reassure at locality/primary care network level.

As in previous years, the scheme will be funded through a top slice from the prescribing budget and the maximum payment available will be £1.00 per patient (using practice population data at January 2020). The split will be as follows:

Table 1: Payments

Element 1: prescribing within budget allocation	£0.15 or £0.30 per registered patient*
Element 2: quality - use of PINCER	£0.30 per registered patient
Element 3: antibacterial items per STAR PU *PLUS* % high risk antimicrobials	£0.15 per registered patient
Element 4: cost saving audit	£0.25 per registered patient
Max total payment	**£1.00 per registered patient**

* payment for Element 1 will be £0.15 per patient if done only at practice level OR £0.30 per patient if done at locality/primary care network level

5.2 Exceptionality

At year end, the Medicines Optimisation Programme Board will consider representations for exceptionality (evidence required), or other significant factors, from practices for achievement adjustments and will have the power to adjust payments due.

6.0 Practice use of incentive scheme payment

All payments received from the PIS must go into practice funds (and not to individuals) for the benefit of patients of the practice. Proposed use of payment must be approved by the OCCG Medicines Optimisation team. The criteria for use of payment is summarised in Appendix 1 and any queries will be arbitrated by the Medicines Optimisation Programme Board or equivalent.

7.0 Key points and summary

- The prescribing incentive scheme (PIS) is designed to increase value for money by improving the quality and cost effectiveness of primary care prescribing. The use of incentive schemes has proved an effective way of incentivising practices to make efficiencies to realise benefits for patient care.
- The scheme offers maximum achievable payment of £1.00 per patient.
- Localities/primary care networks are required to notify the CCG of their decision on element 1, at practice or locality/primary care network level, by 30th June 2019.
- A national PrescQIPP budget setting model provides greater confidence in realistic and achievable budgets.
- Areas for potential savings to aid budget achievement (element 1) will be included in the OCCG Prescribing Data Report which will be discussed at prescribing meetings.

Summary of Prescribing Incentive Scheme 2019-20

Table 1: Conditions required for participation

Condition	Detail
Annual Prescribing Meeting with a CCG Prescribing Adviser in the spring/summer 2019	Discuss the practice priorities and opportunities for the year and agree an approach to scheme achievement. It is expected that all practice clinical staff and, ideally, local Community Pharmacists will be invited to this meeting.
Use of ScriptSwitch by all prescribers	Demonstrate its use through switches being made. This is a useful tool for making cost savings in prescribing as well as informing prescribers about quality issues.

Table 2: Details of the scheme

Element	Target	Rationale
Element 1: Prescribing within budget allocation	2019-20 spend must fall within the allocated budget. This element is offered as an option at either practice or locality/PCN level (to be decided by 30 June 2019).	Use of national tool for budget setting which provides confidence in fair, realistic and achievable practice budgets.
Element 2: Quality – use of the PINCER tool	Practices must run the PINCER searches and upload the anonymised data to CHART on-line. They are required to focus on one safety indicator (which must be different from the safety indicators selected for QOF). After doing a root cause analysis, practices must produce and implement an action plan. Practices are required to inform the Medicines Optimisation team of their choice of safety indicator, provide a brief summary of their root cause analysis and action plan and describe what changes will be embedded into the practice system to avoid the errors recurring. Practices can demonstrate success by showing a reduction in patients at risk from prescribing errors by re-running the searches and uploading the results after a 6 month interval. A reduction in patient numbers is NOT a prerequisite for payment.	By reducing serious medication errors using PINCER, this supports the long term NHS plan by reducing emergency hospital admissions and focussing on prevention of future harms to patients. Training sessions will be run by Primis and facilitated by the AHSN.
Element 3: Antibacterial Prescribing	Antimicrobial items per STAR PU to be below 0.52 (the OCCG average for Q3 and Q4 2016-17) PLUS high risk antimicrobial items (cephalosporins, quinolones and co-amoxiclav) as a % of all antimicrobial items to be < 10% (in line with the national target). This target will be measured using total figures for Q3 and Q4 (i.e. Oct 2019-Mar 2020).	In line with national policy and the Quality Premium, we are continuing to promote good antimicrobial stewardship. The aim is to: ▪ improve the quality of antimicrobial prescribing through the promotion of self-care and management of minor infections, the use of back up

		prescriptions or no prescribing strategies, and education for both patients and clinicians ▪ reduce the incidence of Health Care Associated Infections (HCAIs) e.g. *C.difficile* by decreasing the prescribing of 'high risk', broad spectrum antibiotics e.g. cephalosporins, quinolones and co-amoxiclav
Element 4: Cost saving audit. Practices to choose *one* of the following audits as agreed at their annual prescribing meeting (alternative options may be discussed if necessary). Resources will be available on the scheme webpage		
Element 4a Prescribing of DPP4i drugs in diabetes	All patients on a DPP4 inhibitor should be reviewed and if the DPP4i is effective, switch to the most cost effective choice (alogliptin) using the approved switch protocol. If the patients original DPP4i has not led to a reduction in HbA1c; review the patient's concordance and consider stopping the DPP4 inhibitor and/or adding a different class of medication.	Aligns with the OCCG diabetes MDT project.
Element 4b Prescribing of blood glucose test strips	Review all use of blood glucose test strips: where appropriate, move patients onto meters with cost effective strips in line with most recent CCG guidance (currently strips <£10 for 50, pending update to encourage use of strips <£6 for 50).	Aligns with the OCCG diabetes MDT project.
Element 4c Prescribing of infant formula	▪ ensure all infant formula prescribing falls within the OCCG Infant Formula Guidelines; ▪ ensure parents have advice on the reintroduction of cow's milk using the iMAP Milk Ladder so infants do not continue on prescribable infant formulas beyond the age of 18 months unless under the care of a paediatrician or paediatric dietitian; ▪ check the quantities of milks prescribed to ensure ordering within the suggested amounts as per the OCCG Infant Formula Guidelines.	▪ To ensure infants are reviewed and do not stay on infant formulas longer than is clinically required. ▪ To ensure non-formulary formulas are purchased OTC as similar price to standard formulas. ▪ To ensure appropriate quantities are prescribed by age and to prevent infants gaining excessive amounts of weight.

Appendix 1
Practice use of Incentive scheme payment

Previously, the DH produced interim guidance for PCTs on 'Strategies to Achieve Cost-Effective Prescribing' (June 2007 Gateway reference 8313). This stated "All payments under a [prescribing incentive] scheme should go into practice funds and not to individuals. It is good practice to specify the use of the money, e.g. for the benefit of patients of the practice."

The prescribing incentive scheme shall be such that a prescribing incentive payment shall be made to a practice only on condition that it is to be applied

(a) for the benefit of the patients of the practice;
(b) having regard to the need to ensure value for money;
(c) for any one or more of the purposes specified in Part I (see below) and not for any of the purposes specified in Part II (see below); and
(d) within one year of the end of the financial year in respect of which the prescribing incentive payment was due.

Part I - **Authorised purposes of prescribing incentive scheme payments[1] will include**

1. The purchase of material or equipment that is to be used for the treatment of patients of the members of the practice including diagnostic equipment, ECG machines, blood testing equipment, sterilisers, foetal heart detectors, cryothermic probes.
2. Payments to dieticians or counsellors providing advice on diet, life-style, alcohol consumption or smoking.
3. The purchase of material or equipment which will enhance the comfort or convenience of patients of members of the practice including furniture, furnishings, security features, heating/air conditioning or vending machines for the practice.
4. The purchase of computers including hardware and software.
5. Non-recurring staff costs.
6. Initiatives to improve prescribing.
7. The purchase of material or equipment relating to health education including television, videos, leaflets and posters and payment for advice on how best to disseminate health education advice to patients.

Part II **- Purposes on which prescribing incentive scheme payments may NOT be spent include**

1. The purchases of services or equipment that is unconnected with health care.
2. To reduce a practice's contribution to the employment costs of existing practice staff.
3. The purchase of land, or premises, or replacement windows.
4. To pay off pre-existing loans taken out by the members of the practice.
5. The purchase of drugs, medicines or appliances.
6. The purchase of hospital services.
7. Mobile phones.

NB. Funding will *only* be approved if the above guidance is adhered to ie. (a), (b), (c) and (d) as well as Parts I and II above *all* need to be met.
Any queries will be arbitrated by the Medicines Optimisation Programme Board (or equivalent).

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[1]Statutory Instrument
1998 No.632