

# A MORE CREATIVE APPROACH to budget setting?

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In April 2000, the three primary care groups in Hillingdon Health Authority merged to become the largest first-level primary care trust (PCT) in the country. The health authority (HA) retained only a skeleton structure and most of its functions were devolved to the PCT. The HA pharmaceutical advisers role has been retained by one of the locality pharmaceutical advisers (PAs) but much of the implementation of policy is devolved to the PCT prescribing team. The PCT comprises three distinct localities, covering a population of 250,000 patients. Each locality has its own board and management team, which includes a pharmaceutical adviser. The PCT has a cash-limited unified budget, which is devolved down to locality level which has allowed far greater flexibility on how the money is used.

## The changing role of the pharmaceutical adviser

Since the inception of primary care groups, the role of the PA has changed substantially. The original remit of PAs was to provide practice-based support and to have some strategic responsibilities. In addition, budget management was always a large part of the PA's role. However, since PCTs came into being, the role of PAs has become much more strategic, with less time devoted to practice-based work. In light of this, Hillingdon PCT is in the process of appointing three locality assistant PAs, who will largely be practice-based.

The expanding role of PAs has meant greater involvement with national and local priorities such as the implementation of national service frameworks and guidance from the National Institute for Clinical Excellence, in addition to many of the traditional HA roles (eg, community pharmacy-based projects). This in turn has allowed the development of prescribing and medicines management projects to be more fully integrated into the overall primary care agenda than ever before. This has been clearly illustrated by the development of health economy-wide disease management guidelines in place of separate prescribing guidelines. PAs have been project managers in producing these guidelines, working across the primary/secondary care interface, rather than just being specialists providing information on drugs as in the past.

## Greater flexibility with locality budgets

The new culture of locality-based budgets and management teams has led to more imaginative use of the prescribing budget. The total PCT prescribing budget for Hillingdon for 2001/2 is £24m. This is devolved down to the localities to distribute among practices as they see fit. Unusually, the PAs' salaries are paid out of the prescribing budget, not from management costs.

The three pharmaceutical advisers work

closely in setting their own locality and practice budgets, and have tried to use common principles wherever possible to ensure consistency across the PCT. The high-cost drugs element of the budget is shared between the three localities, allowing the cost of expensive drugs to be spread over a greater number of practices.

My locality, Hayes and Harlington, has the smallest population of the three localities and has a prescribing budget of £6m. From this, a contingency of £158,000 has been top-sliced, along with £50,000 for the prescribing incentive scheme. In addition to this, a further £25,000 has been top-sliced for prescribing projects. This will be used to provide support to practices for NSF implementation and audit work. The majority of this money will be used for projects that involve community pharmacists, either through session work within practices or through specific community pharmacy-based projects. We have successfully used this model in the locality for the past two years.

During 1998/9, Hayes and Harlington was a commissioning group pilot and achieved a saving of over £200,000, compared with the previous year, when it had had a slight overspend. During that financial year, the work done at practice level with the support of sessional community pharmacists proved that this type of relatively small investment can improve the cost-effectiveness of prescribing. It also sent a clear message to practices that the management team was

willing to provide much-needed support and to work more closely with them than the HA had been able to in the past. The PCG board at the time, was so keen to maintain the early momentum that it agreed to top-slice a further £25,000 from the commissioning group savings for the following year.

Sadly, PCT status and the corresponding move to unified budgets has proved to be a disincentive as far as the prescribing budget is concerned at least for 2000/01. The locality made a saving of £130,000 but found that this was swallowed up by deficits elsewhere, most notably in the acute trust. This has left local GPs feeling that there is little incentive to control prescribing budgets some have said they wished they had not bothered to prescribe cost-effectively. However, we are stressing the importance of continuing the good work, so that we can afford to implement NSF's and NICE guidance.

#### Implementing NSF's

There has also been some discussion within the PCT about whether more of the budget could be top-sliced for specific prescribing or for NSF related projects. For example, nursing time has been reduced by 50 per cent within the locality and some of the money saved by this could perhaps be used to provide specific prescribing-related clinics run by agency nurses or community pharmacists. The risk of such a strategy would be that there would be little contingency money available and an unpredictable shift in prescribing patterns, such as the generic price increases of last year, could lead to a massive overspend.

The implementation of disease management guidelines and NSF's will inevitably lead to an increase in prescribing costs. At Hillingdon, we have been working to set up a method to identify where these potential increases might occur. For example, we carried out an extensive baseline audit into prescribing for people with diabetes. In addition to establishing the current clinical picture, the data was used to project the likely cost of implementing local diabetes guidelines. This audit identified that a £2m increase in spending would be needed to meet the targets set. To put this

into perspective, the entire prescribing uplift for the year was £1.7m. Clearly, we are not likely to implement the changes fully in a short space of time, and uptake will probably be gradual. We will continue the audit process alongside cost modelling, so that we can monitor progress.

The locality will be taking the view that, as long as the increases in cost are mirrored by improved clinical outcomes (as demonstrated by the audits) then practices will be supported in increasing their spending. Over the past three years, we have been working on improving prescribing of ulcer-healing drugs, non-steroidal anti-inflammatory drugs, generic prescribing, and repeat prescribing systems, among other things. Thus, practices will continue to be encouraged to maintain cost-effective prescribing in many therapeutic areas.

We are expecting to follow a similar audit model for other therapeutic areas as we develop new guidelines and more NSF's arrive. For example, we have recently completed mental health guidelines, which recommend atypical antipsychotics as first-line therapy for schizophrenia.

#### NICE guidance

Another cost pressure on prescribing has been guidance from the NICE. Implementing this guidance is difficult in the first year, because there is no additional funding for doing so the increased costs have to be found from within annual growth. The PAs have been keen to point out to PCT management that for many of these guidelines to be implemented, there will have to be changes in service provision.

We currently have a three-tiered process:

- Level one Guidance that we are already implementing and, therefore, for which no further changes are required (eg, reducing prescribing of proton pump inhibitors).
- Level two Guidance that could be provided through the current set up but which is likely to result in an increase in costs

(eg, rosiglitazone).

- Level three Guidance implementation that would require changes to be made to service provision. For example, if use of drugs for treating dementia is adopted, memory clinics will be needed before we could prescribe and appropriately monitor patients in order to follow the guidance.

Our recommendations are reported to the area prescribing committee and then forwarded to the relevant groups within the PCT area. This mechanism has been well received within the PCT and further strengthens our belief that our approach of integrating prescribing within general disease management and service provision, is the right one for the future.

In the early days of PCGs, managers and board members often saw the prescribing budget as an easy way to make savings. With the advent of NSF's and the NICE guidance, there is now more pressure than ever to keep within budgets. Our experience has shown that there is a definite shift in emphasis from containing costs to a quality agenda. However, this will come at a price. PAs need to work within their own organisations to identify what prescribing costs will be and to put in place measures to show corresponding increases in quality. To do this, they cannot work in isolation as specialists with drug knowledge. PAs need to see themselves as health care managers with a clinical background.