INTRODUCTION

Prescribing is now the most common therapeutic approach taken when treating patients in the NHS. On average, a general practitioner prescribes between 250 and 350 prescription items every week. Each time an item is prescribed it usually involves the GP working through a complex professional process including: ***investigation, evaluation, option appraisal, patient customisation, communication, agreement and then recording the decision.***

Over time, most GPs develop personal strategies to manage this important and potentially time-consuming activity. However, underpinning each of the above elements there can often be a range of supporting activities that, if done well, significantly improve the efficiency and cost-effectiveness of the prescribing process – ultimately to the benefit of the patient, the GP and the NHS.

GPs' overall workload has increased considerably over the last few years. Inevitably this puts pressure on important professional activities such as keeping up to date with emerging clinical developments, as well as maintaining the surgery's management and information systems which support current medical practice.

This pressure is no more acutely seen than in the area of prescribing because of the rapidly increasing number, potency and cost of medicines becoming available for use. With the development of Primary Care Groups (PCGs) in the "New NHS", GPs will have much greater flexibility to decide how best to spend their local healthcare budgets in order to maximise health-gain for their patients.

Optimising medicine use is one of the major challenges that will present itself to practices and PCGs over the coming months and years. However, making the most of this opportunity will require considerable additional professional input and support at both practice and PCG level – but what is the scope of this extra prescribing support work and how should it be achieved?

The concept of ***"Prescribing Support***" is not new, however, few GPs and other relevant professionals and managers will be aware of the breadth of potentially useful initiatives currently being undertaken in the NHS.

This document is designed as a one-stop, user-friendly resource aimed at those concerned with optimising prescribing for patients and maximising the use of available resources within the NHS. It outlines a wide range of services that, when implemented effectively, can support GPs (and others) in their prescribing activities. It gives details of some of the initiatives that have already been tested *in-situ* and outlines how to choose which services would be most relevant to the local situation and how go about commissioning them.

Key audiences for this document will include:

- GPs within PCGs, who are considering whether, and what type of prescribing support is relevant to their practice situation.
- PCGs, who are in the early stages of developing corporate models of prescribing support which suit their local circumstances.
- HAs, to help them develop effective prescribing support within PCGs.

Prescribing support could be defined as the use of additional professional input into one or more elements involved in the prescribing process. It has the overall objectives of promoting high quality, cost-effective medicine use and of improving the pharmaceutical care of patients. This should allow NHS resources to be used more effectively and practices to operate with greater efficiency, allowing GPs more time to spend with individual patients and also to improve the health of their practice's population.

1.1 BACKGROUND

Improving quality and efficiency in the NHS are key objectives of the government's reforms, described in the recent White Paper "The New NHS"[1]. The National Institute for Clinical Excellence (NICE) will give a strong lead on clinical and cost-effectiveness, drawing up new guidelines from the latest scientific evidence. Long-term service agreements will replace annual contracts between HAs, PCGs and NHS Trusts, and will include explicit quality standards. A new system of clinical governance will help ensure that clinical standards are met and that there are processes to promote continuous improvement. Clinicians in primary and secondary care will need to ensure that there are systems in place to deliver good clinical care. Help will be required not only to achieve locally agreed targets, but also regional and national targets.

PCGs will take varying levels of devolved responsibility for a single unified budget covering most aspects of care. Health Improvement Programmes (HIPs) will address the most important health needs of the local population and outline how these are to be met. Prescribing issues are likely to form an important part of any health improvement programme.

Drug expenditure by GPs in England accounts for approximately £4.5billion annually, representing about 50% of costs in primary care. This expenditure is currently rising at 9% per annum.

There will be an increasing need to demonstrate that all prescribing is cost-effective in the context of the NHS as a whole, and greater collaboration between primary and secondary care will be essential. Managing the entry of new drugs into the NHS will require co-operation between clinicians, other professionals and managers in primary and secondary care on a scale far beyond that seen at present. With the whole of prescribing coming within cash-limited unified budgets, there will be a real need to make sound, cost-effective, evidence-based decisions.

Until recently, medical and pharmaceutical advisers provided the mainstay of formal prescribing advice and support to GPs at a local level. It is becoming clear that there is a need for a greater local support of the prescribing process beyond that able to be provided by the HA. Therefore, many locally led initiatives have looked at additional models of providing prescribing support. These initiatives have considered the role of various healthcare professionals in the prescribing process, for example

pharmacists and nurses. In addition, in 1995 the Department of Health funded 17 projects to further consider different models of providing prescribing support to GPs.

This document summarises a wide range of potentially relevant initiatives for GPs and others to consider in the new NHS environment. The vast majority of these initiatives so far have involved pharmacists, although some models utilise the skills of other healthcare professionals. This in no way diminishes the potential roles for others, indeed in some important areas there is a need to make use of specific expertise e.g. nurses in wound management, dieticians in nutritional support etc.

Enthusiasm for these initiatives has been significant amongst almost all those involved, and evidence to date (see appendix 1 and 2) suggests that investment in prescribing support, when implemented effectively, is a valid approach to facilitating the management of primary care prescribing.

1.2 EVIDENCE FOR PRESCRIBING SUPPORT

There has been a range of articles published that consider the effectiveness of various interventions aimed at altering prescribing behaviour. It is generally recognised that passive knowledge distribution (e.g. distributing practice guidelines) is insufficient to improve clinical practice without supplemental interventions. Davis *et al* published a literature review[2], which concluded that commonly used methods of delivering education, such as conferences, have only limited impact on improving professional practice. More effective approaches include systematic practice-based interventions and outreach visits.

This resource document is therefore, timely in describing a whole range of prescribing support interventions that have been tested at local level. They all aim to bring about changes to the prescribing process and thereby improve clinical practice through more efficient and effective delivery and use of medicines. A fuller review of the literature on this subject is included in appendix 3.

1.3 WHY READ ANY FURTHER?

GPs, like all other healthcare professionals, are finding increasing demands being made on their time. The availability of new and innovative treatments for previously untreatable conditions, linked to greater patient demand and an increasing need to maximise health gain within finite resources, put pressure on an already stretched service.

The use of information technology (IT) has the potential to revolutionise the way services are organised and how information is transferred around the NHS. However, IT alone will not deliver better and more cost-effective patient care. Considerable additional professional input will be required.

So, what are the issues that could lead a GP practice or PCG to consider utilising one or more prescribing support services?

≫ **Patient gain**	Improved quality of the prescribing process leads to better patient care.
≫ **Better use of GP time**	Delegation of some prescribing-associated processes and the implementation of more efficient systems allow the GP to concentrate more on other areas of patient care.
≫ **Health improvement**	Practices and PCGs will have targets aimed at improving the health of their patients. Several of these targets will be related to prescribing, e.g. a decrease in NSAID-related bleeds, or optimum use of aspirin for the secondary prevention of cerebrovascular or cardiovascular disease.
≫ **Equity**	Within practices, PCGs and beyond there is a need for greater equity in patient care, including prescribing.
≫ **Clinical governance**	Increasingly there will be intolerance of inappropriate variation in medical practice and peer pressure linked to relevant support could help to harmonise prescribing within PCGs.
≫ **Closer working between GPs**	The introduction of PCGs will without doubt lead to closer working relationships between their constituent GPs. Many prescribing issues tend to be common to all prescribers and are a possible starting point for joint working between practices.
≫ **Trouble-shooting primary/ secondary care issues**	Unified budgets will facilitate the resolution of a range of problems which have occurred between primary and secondary care; for example cost-shifting of specialist drugs into primary care, lack of communication resulting in medication changes not being implemented, and inadequate patient follow-up after admission to or discharge from hospital.
≫ **Medicines use – the whole picture**	Generally, GPs concentrate on prescribed medicines, but should increasingly be considering medicines use as a whole; for example medicines bought over-the counter. Community pharmacists may have a fuller picture of some patients' total usage of medicines, including their adherence to prescribed medicines. There are many occasions when a patient's actual medicines use differs considerably from the record of prescribed medicines held by the GP.
≫ **Continuing medical education**	Continuing medical education is an important part of a GP's professional life. As the majority of interventions that a GP makes involve medicines, continuing education will be important in the drive to improve standards of care. GPs' ability to keep up to date with information on drugs could be aided by additional support.

1.4 PRESCRIBING SUPPORT MODELS

The models for prescribing support described in this document represent tested options of more efficiently managing the prescribing process. Almost all those who have been involved in initiatives so far agree that there is a significant role for prescribing support throughout the NHS, in order that medicines use can be managed even more efficiently and cost-effectively. Work to date has demonstrated the benefits of co-ordination and implementation of prescribing policies both within and across practices, the closer involvement of pharmacists in day to day medicines management, and an improvement in the use of scarce resources through more efficient prescribing systems and decision-making processes.

Professional prescribing support can be described under various headings. GP practices that are just beginning to appreciate the benefits of prescribing support may initially decide to commission one or two specific services, based on the most pressing needs of their practice, as a way of sampling the range available. Those who already have experience of prescribing support will appreciate that it could well be covering many more of the areas described.

Later in the document is guidance on how to assess what services might be needed and how to commission them. Some services can be provided on a sessional basis, for example weekly or fortnightly. However, increasing numbers of practices or groups of practices are now commissioning significantly more input than this, for example one or two days per week, or even full-time. Such an arrangement allows fuller involvement in the day-to-day management of prescribing processes in the practice.

The majority of the services described are applicable at both practice and PCG level. HA input will remain important as PCGs evolve and then increasingly in a strategic development and coordination capacity. How services are purchased and organised will depend on the configurations of PCGs and the pace of change. Learning from the experiences of those who have already been involved in prescribing support is essential if effective services are to be developed locally.

A senior GP with significant experience of prescribing support provided the following commentary:

> To prescribe is second nature to me as to any GP – but do I pay enough attention to the detail of each medicine or dressing I give to a patient to ensure the best outcome? I know I do not. The five golden rules of rational prescribing – safe, effective, acceptable, available and economic – do not spring to mind every time I write a prescription.
>
> Cost, unfortunately, is something we are constantly reminded to consider. To our patients, individually, cost is irrelevant. How then can we make it relevant but remain able to say we prescribe sensibly and ensure that "distributive justice" is practised?
>
> The practice pharmacist adjusts our formulary daily and advises us and our patients about medicines. Repeat prescribing is controlled and our receptionists no longer have the worry of answering queries about medication when no GP is available. Services to patients are vastly better – fewer adverse events, more individually tailored regimens, no queuing in "cattle market" anticoagulant clinics and concordance issues are starting to be addressed.
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> Without the practice pharmacist our prescribing costs could not have been consistently 15% below the national PACT average for three years (they are now 24% below) but still incorporate prescribing which is safe but simple, effective but efficient, available but appropriate, acceptable and appreciated and still control costs without conscious thought.
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> The practice pharmacist is the "ship's engineer" and our ship is now fully manned and continuously in commission.
>
> *Dr Denys Wells, GP, Northgate Medical Centre, Walsall.*

The next few chapters describe the range and scope of prescribing support services. For convenience they have been divided into three types of service: "clinical", "prescribing policies, procedures and analyses" and "issues and policy at the interface". Chapter 5 then describes how to go about commissioning a prescribing support service, having reviewed the options in chapters 2, 3 and 4. The appendices contain further useful and detailed information for those involved in commissioning, or providing them.