5 WHERE TO START

It should now be clear that there are a wide range of prescribing support services potentially available. But how does a practice, PCG or HA decide where to start? The first step is to identify any obvious prescribing problems that may exist. These may include clinical practice that does not consistently match “best practice”, an overspend on its prescribing budget, repeat prescribing which is difficult to manage, or a lack of professional time to continually review and optimise patients’ prescriptions.

5.1 HOW TO ASSESS WHAT SERVICE IS NEEDED

Having reviewed the various services described in this document, a practice or PCG needs to decide what their areas of greatest need are with regard to prescribing issues. The advice of the HA prescribing adviser should also be sought at this stage.

Unless a proper assessment of the practice's needs is undertaken, there is a risk that the practice could engage someone to carry out an ill-defined or inappropriate task and the initiative may not be successful. It may also be helpful to talk to practices who already have experience of prescribing support services.

The following questions may be areas within a practice or PCG which could usefully be addressed by an appropriate prescribing support service:

- Is the repeat prescribing process inefficient?
- Is the prescribing evidence-based?
- Does care of patients with a particular condition need to be brought in line with best practice?
- Does prescribing in nursing/residential homes need review?
- Are prescribing costs above average?
- Is prescribing expenditure over budget?
- Is the practice computer used ineffectively?
- Is there lack of time to address problems and improve quality?
- Do local hospitals impact on primary care prescribing?

Following an initial assessment it should be decided which model(s) is/are best suited to the circumstances identified. It may be that several of the areas listed above would benefit from improvement, but it is important to prioritise according to the perceived deficiencies in each area. The HA prescribing adviser may be able to carry out an assessment of the practice's prescribing or provide information on performance in certain areas, to help determine the most appropriate prescribing support required.

It should be remembered that different services will deliver different

benefits in different timescales.

In Leeds, community pharmacists met monthly with a GP practice to review prescribing in different therapeutic areas. As a result of this initiative, several GPs went on to involve their pharmacist more closely in further areas of work:

- one practice has asked their pharmacist to hold an outreach clinic on inhaler technique and patient concordance, to coincide with the practice's asthma clinic
- another practice asked its pharmacist to write the prescribing component of their business plan
- one pharmacist is to train practice staff in prescription management

Department of Health Project – see appendix 1, page 78

A practice or PCG may feel the need to look for savings in some areas in order to release resources to spend in other areas. For example, the introduction of more cost-effective prescribing for one disorder, will release resources for implementation of evidence-based medicine in another, in line with published research and guidelines; e.g. greater use of statins.

Increasingly PCGs will need to develop a strategy to determine which GP practices, or areas of work are a priority, and then commission and allocate the resources appropriately. As PCGs develop, they are likely to take a view on prescribing issues to be addressed, over and above those at individual practice level.

5.2 HOW TO COMMISSION A GOOD SERVICE

Once a practice, PCG or HA has defined its objectives in purchasing prescribing support, they then need to go about commissioning the service they require.

It is always wise to talk to people with experience of a similar service, such as GPs who already employ a pharmacist, those already providing a service, and HA medical and pharmaceutical advisers.

5.3 FUNDING A SERVICE

Some services may be purchased as a complete package. Other services may involve the employment of individual professionals. When costing out such a service the following should be considered:

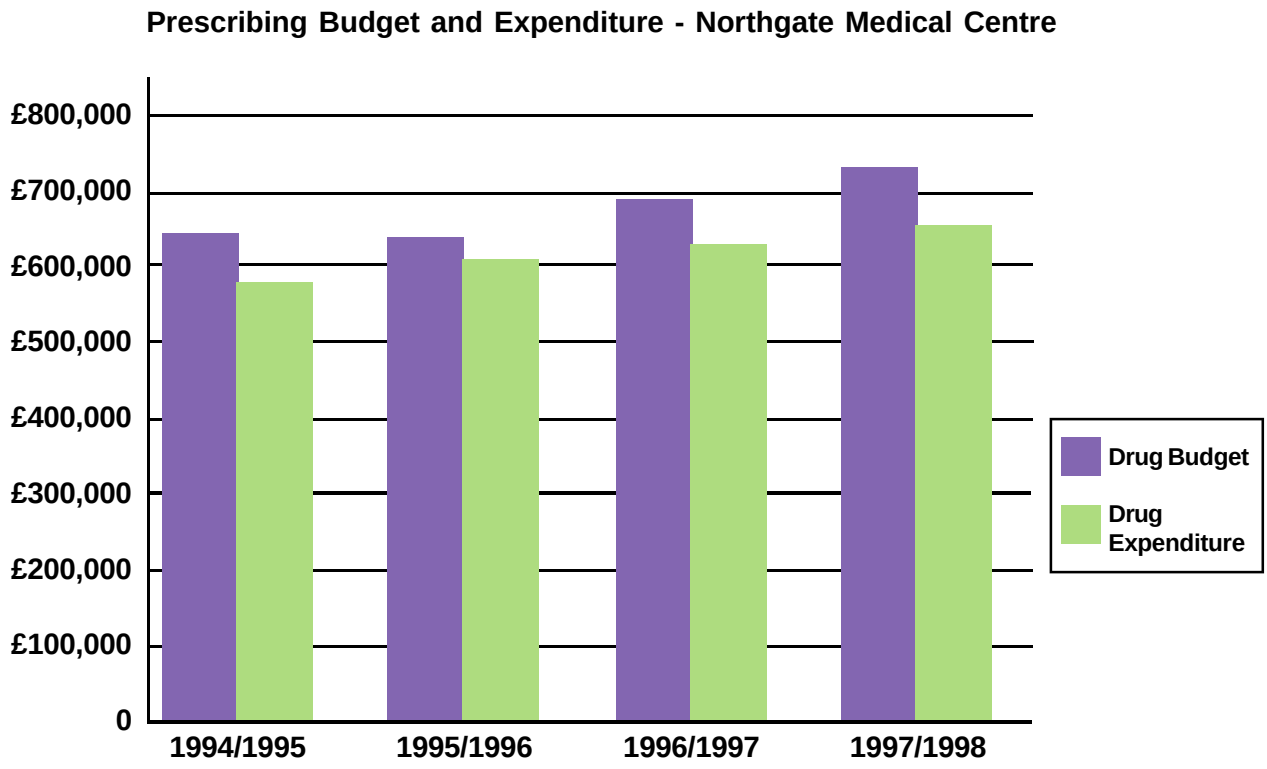
- the professional's fee for time spent both in the practice and in preparation time
- locum cover if necessary (e.g. for the community pharmacist)
- travel expenses e.g. for domiciliary visits
- overtime for practice staff
- locum cover for GPs e.g. for formulary "away day"
- stationery costs e.g. for patient information leaflets
- additional computer equipment and space for it in the practice
- secretarial support
- mobile phone if the professional is working for several practices
- subscriptions to professional databases e.g. electronic BNF/MeRec/DTB on CD-ROM
- training/study days
- if employing a practice-based pharmacist, additional consideration needs to be given to national insurance contributions, sick pay, maternity entitlement and indemnity cover

There are several ways of potentially funding prescribing support including:

- prescribing budgets
- other elements of PCG allocations
- GMS monies
- other HA funding streams
- exchange of services, e.g. use of a Trust pharmacist in exchange for additional work carried out by the practice for the Trust
- practice development funds

A five-partner practice with a patient population of 9,000 will have a prescribing budget of around £650,000. Many of the services described may lead to reductions in prescribing expenditure in certain areas. Inevitably this will depend on the nature of the practice, the nature of the service and whether the main objective is to make quality improvements or reduce expenditure. However, it is useful to consider examples of savings made versus the costs of prescribing support services:

The Northgate Medical Centre has had a full-time practice pharmacist for four years. The practice has consistently made savings on their prescribing budget far in excess of the costs of employing a full-time pharmacist. These visible cost savings are in addition to the "hidden" savings from improved patient care, more efficient service provision and fewer referrals to hospital.



The Wirral Total Purchasing Pilot project employed a pharmacist for three days per week. In 1996/97 this initiative reduced the prescribing overspend from £153,000 to £52,000.

As an example, the average salary of a D/E grade pharmacist (hospital pay scale) is around £27,000 pa.

5.4 RECRUITMENT

Having decided on a service and how to fund it, the next step is to recruit a suitable applicant. The recruitment process should test that the applicant has the skills necessary for the job. This may include:

- examples of previous work
- communication skills
- clinical knowledge
- an insight into medical and other influences on prescribing
- relevant experience
- motivation and interest in this type of work
- a commitment to continuing personal development
- an awareness of particular issues affecting prescribing (e.g. working in an area with high numbers of ethnic minorities)

(From the Audit Commission[7])

The person employed will need to have the routine skills necessary to perform the job. But remember that it is performance that matters. Some skills will be required before undertaking some of these services, but others will be acquired "on the job". Professionals from different backgrounds will have different skills. For example, a hospital pharmacist may have clinical skills in a particular therapeutic area, may have direct experience of devising formularies, and on occasions might have had more formal clinical training. A community pharmacist may have the skills to advise on and manage repeat prescribing systems within a practice. They are likely to have more experience of primary care and may already dispense for some of the practice's patients. Community pharmacists will have a closer understanding of the Drug Tariff and OTC products but will know less about hospital discharge and admission policies than their hospital colleagues.

There may be other reasons why a practice might want to form closer links with a local community pharmacist, for example to strengthen the primary healthcare team.

"We like having our local community pharmacist provide our prescribing support as it helps to ensure seamless patient care. When our patients have their prescriptions dispensed, we know the pharmacist understands the rationale behind the prescribing decision because she has helped us to develop the policy. This means the local pharmacist can reinforce the benefits of treatment to the patient. It has also improved our effectiveness as a primary care team. We regularly discuss individual patients with the pharmacist and find joint solutions to medication related problems. The local pharmacist also attends our practice review meetings, which helps with team working and brings a different perspective to our discussions.

Despite the fact that we do not share premises, our local community pharmacist is a key player in the primary health care team. This is what the new NHS is all about."

Dr Michael Drake and Partners, Bennetts End Surgery, Gatecroft, Hemel Hempstead.

More recently a number of independent pharmacists with experience in one or both sectors have moved into the prescribing advice and support arena; as with others, their skills will depend on their prior experience and training. For further information about the particular skills that pharmacists possess, see appendix 8.

It may be worth enlisting the input of the HA prescribing adviser when recruiting, to help ensure that the right person is selected for the job. Recruitment may be through formal advertisement in the professional journals, or more local processes and contacts.

It should be noted however that there are a finite number of pharmacists and other professionals able and willing to take on these roles. Therefore, a group of practices, or a PCG, may wish in time to consider employing a range of staff. For example, nurses have excellent skills in running clinics and in counselling patients. Also qualified pharmacy technicians working under the guidance of a practice pharmacist could undertake some of the routine tasks described above, such as teaching inhaler technique, doing computer searches etc.

5.5 EMPLOYMENT OPTIONS AND CONTRACTUAL ARRANGEMENTS

Employment arrangements should reflect the needs of the practice or PCG, and the person providing the service. There are several options including:

- direct employment on a full time, part time or sessional basis by a GP practice
- employment by one practice on behalf of a group of practices, with each practice being invoiced for their share
- employment by a HA
- secondment from, or through a contract with, a local Trust, academic unit or community pharmacy
- a self-employed professional working on an individual or sessional or consultancy basis
- a contract with a commercial advisory company providing prescribing advice services

A service agreement should be set up which includes the following elements:

- a brief but clear description of the service to be provided and/or a job description
- a confidentiality clause
- details of professional fees, locum costs and other expenses which will be paid
- hours of work
- arrangements for sick leave, holidays etc.
- an agreement about time allowed to attend training sessions
- what training will be required and who will pay for this
- arrangements for indemnity insurance, if required
- line management arrangements - professional responsibility and managerial accountability
- performance management arrangements
- notice arrangements

An example of a job description for a full time prescribing support pharmacist and a sessional practice pharmacist can be found in appendix 10.

5.6 GETTING STARTED

All GPs, nurses and practice staff need to be informed about, and where appropriate involved in the commissioning of prescribing support. Depending on the level of prescribing support required, the person employed should receive some sort of introduction to the practice/PCG. For short-term or sessional arrangements, this may simply be an introduction to all members of the practice team, and an initial discussion with the key players to define objectives, processes and desired outcomes of the service. For longer-term arrangements, or those involving several sessions per week, a more formal induction programme may be appropriate. This should involve meeting all members of the primary healthcare team, including local community and hospital pharmacists.

In addition, practice systems and ways of working should be explained and observed. All GPs need to be confident in the ability of the person they will be working with. To build up confidences and relationships it is best to start with a straightforward area of work. This allows time to acclimatise to life in the practice and get to know the staff. The keys to successful working are:

- good communication and relationships between all involved
- adequate computing and administrative support
- support for the implementation of practice decisions
- ensuring that patients know about the prescribing support service
- ensuring that all personnel involved are part of the practice team
- ensuring that changes have been agreed with the doctors
- ensuring that delegated authority has been given to alter medication on behalf of the doctors, where relevant

Beware of being too ambitious initially. It is far better to allow small, discrete projects evolve into more significant pieces of work, as all the healthcare professionals involved will then feel happy to progress.

If a practice, or PCG, is predicting an overspend on its prescribing budget, there are on occasions various “quick fixes” which can be implemented to help reduce an overspend (see appendix 5). Bear in mind that the earlier on in the year that changes are implemented, the greater their financial impact. A targeted switch to generic prescribing in February or March is unlikely to make much difference until the following financial year.

Any quick changes to prescribing patterns must be thoroughly thought through, and each process considered as to what, if any, the likely impact on patient care, and their subsequent adherence with medicines, is likely to be. It is important that all partners agree to the changes, and that a process for informing patients about these changes is developed. Liaison with local community pharmacists is important so that they are aware of major changes in prescribing in advance of their implementation. The support of the local community pharmacist is invaluable as they can reinforce advice given to patients about the need for, and benefits of, changes in medication.

When developing a prescribing support service, it is important to avoid some of the well-known predictors of failure. These include:

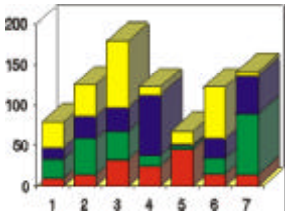
- not getting all partners and practice staff to agree to a change
- agreeing a change but not implementing it
- not following through changes with patients, so that patients are reluctant to accept the change
- not involving local community pharmacists or getting their support
- a lack of follow-up and maintenance of the changes implemented, so that over time things revert back to how they were

General guidance on how to carry out several of the services described earlier in the document is included in appendix 5.

Those providing some of the services outlined in this document may need access to patient records in order to make fully informed recommendations. However, patients have a right to confidentiality, and before information can be shared, patients must have been informed in general terms of how this information might be used. Guidance from the Department of Health ("The Protection and use of Patient Information) states that all NHS bodies must have an active policy for informing patients of the kind of purposes for which information about them is collected; it includes a model notice for display within the practice. Practices will want to make sure that their mechanisms for informing patients reflects the full range of information-sharing possibilities within the practice. It should be remembered that all healthcare professionals have an ethical duty to keep patient information confidential.

5.7 ONGOING SUPPORT

All those working with GP practices to provide prescribing support/advice will need some assistance, which could be co-ordinated via the HA. Health authorities should be asked in advance about what support they could realistically provide and how. It may for example include:



- PACT data for the GP practices with whom they are working
- other HA prescribing information
- access to information resources e.g. local drug information services
- standard drug information resources e.g. MeReC bulletin, Drug and Therapeutics Bulletin and in future, outputs from NICE
- therapeutic review summaries and workshop outputs from the National Prescribing Centre
- information from the Cochrane Database, Centre for Reviews and Dissemination etc.
- education and training e.g. as provided by Centre for Pharmacy Postgraduate Education and the National Prescribing Centre
- examples of locally developed guidelines, patient information leaflets, posters etc.
- word-processing, spreadsheeting, desktop publishing and other secretarial training
- facilitation of support networks between those providing similar services

Many national information sources are increasingly available on the Internet e.g. major medical publications, the Cochrane database and CSM bulletins. Nationally, initiatives such as some of those already described are further supported by the NHS Executive, the National Prescribing Centre and other bodies.

5.8 MONITORING THE EFFECTIVENESS OF THE SERVICE

Part of initiating a new service is defining the required outcomes. Once defined, those outcomes need to be monitored, to determine whether the initiative is achieving its objectives and is value for money.

There are many ways of monitoring the effectiveness of the services described. It is important that the method is chosen at the start of the initiative, so that any information required can be collected along the way. It is generally more difficult to gather data retrospectively.

On the following page are examples of indicators that may be relevant to some of the services being provided.

No indicator gives a comprehensive view of prescribing quality, but some have been devised which are a useful starting point to monitor prescribing in major areas of disease. Examples include Memphis Indicators from the Department of Health, or the indicators developed in the Northern and Yorkshire Region.

Examples of indicators used to monitor prescribing change

Review of PACT Data

PACT data can be analysed to track any changes in prescribing. HAs have an electronic version of PACT data, called EPACT, which can plot trends in prescribing over time, compare practices with each other or the HA average and graphically represent all aspects of the PACT catalogue. This is already used for routine and ad hoc dissemination of prescribing information to practices, although there may be workload implications for the HA if requests for this information increase significantly.

Prescribing per ASTRO PU

To show changes in expenditure on prescribing it is often useful to look at prescribing expenditure per ASTRO PU. This is a measure of expenditure per head of population, weighted for age, sex and temporary resident status. It can be used to show changes in prescribing expenditure over time or to compare practices within a PCG.

Patient Medication Records

Most community pharmacists store information on items dispensed, in their computerised patient medication record (PMR). As this information is available more instantly than PACT data, it can be useful to show changes in a practice's prescribing, provided the majority of a practice's prescriptions are dispensed at that pharmacy.

Adherence to a Formulary

PACT data can also be used to qualify adherence to a formulary. The percentage of prescribing in a therapeutic area which was from the formulary can be calculated at the start of the initiative. Progress towards target percentage adherence can then be monitored.

Practice Comparisons

Comparison with other practices, the HA, the Region or the national picture can give an idea of how a practice is performing in relation to colleagues.

Comparisons with matched control practices not participating in any initiative can be a way of demonstrating the effectiveness of a service. However, it is difficult to find true matched controls and eliminate bias.

Outcome of Planned Interventions

If a practice decides to undertake a particular intervention, for example aligning nursing home prescribing to a 28-day supply cycle, then one measure of success may simply be the number of prescriptions requested for a nursing home before the next batch of prescriptions is due.

Clinical Audits

Specific clinical audits could look at number of patients treated in line with guidelines. They also may look at particular clinical outcomes. These may be longer-term audits; for example, an initiative to target the use of aspirin should eventually show improvements in the number of fatal and non-fatal myocardial infarctions, strokes etc.

Examples of Standard Prescribing Indicators

Drugs of Limited Clinical Value

e.g. expenditure on peripheral and cerebral vasodilators, topical nasal decongestants, antidiarrhoeal drugs.

Premium Price Preparations

e.g. expenditure on modified-release preparations of propranolol, isosorbide mononitrate, salbutamol, diclofenac and other NSAIDs and combination products such as Frumil, Moduretic, Tylex and Remedeine.

Benzodiazepines

e.g. the number of defined daily doses per patient or per STAR PU.

Source: Memphis Prescribing Indicators, distributed by the Prescription Pricing Authority

Quantitative outcomes are generally easy to measure and an effective way of demonstrating success or otherwise. However, qualitative assessments of an initiative are just as important in demonstrating patient benefit, NHS efficiency and improved conditions of working within a practice. Interviews with staff, patients and other participants often reveal shortcomings or benefits of an intervention that are not apparent through quantitative assessments. The GPs' view on the success or otherwise is an essential part of monitoring the effectiveness of a service. Without GP acceptance and ownership of an initiative, it is unlikely to succeed in the long-term.

Nationally, there is a need to co-ordinate the collation of evidence on the impact of prescribing support interventions for future evaluation. Regional Research and Development programmes have the potential to accept bids to formally evaluate the effects of prescribing support locally.

An example of a prescribing support project which is being evaluated formally, is summarised overleaf.

In 1993/4 Doncaster Health Authority had the highest GP prescribing costs per patient of all HAs in the country. The Authority decided to invest in a scheme whereby pharmacists would work in general practices and support GPs' prescribing activity, with the aims of controlling prescribing costs while maintaining (or improving) the quality of prescribing.

Eight practices and one total purchasing pilot (another nine practices) took part in the initiative. These practices covered 30% of the population of the Doncaster Health Authority area. Six pharmacists (5.7 WTE) were recruited to work with the practices.

Changes in overall prescribing for the Prescriber Support Project (PSP) practices and a group of control practices were compared between the year before the project commenced (September 1995 to August 1996) and its first year of operation (September 1996 to August 1997). The key findings were that:

- while NIC/ASTRO PU increased by only 3.4% in the PSP practices, the rise was 9.2% in control practices
- if the PSP practices' prescribing expenditure had increased at the same rate as their controls, their expenditure would have been £363,000 more than it actually was
- the running costs of the first year of the project were £163,000. Therefore, it is estimated that the project made a net initial saving of £200,000
- the rate of generic prescribing increased on average by 4.7% in the PSP practices compared with 1.7% in the controls
- the differences between PSP and control practices in their changes in prescribing costs and generic prescribing were statistically significant (the likelihood of any of these findings occurring by change alone was less than 1 in 40)
- while there was a small increase in the number of items prescribed per ASTRO PU in both PSP and control practices, there were no significant differences between the two groups of practices
- the percentage increase in net ingredient costs in control practices (8.4%) was similar to the increase in the ten HAs most similar to Doncaster for the same time period (8.5%)

Analysis of prescribing data showed that PSP practices made relative savings in the following areas:

- replacing brand-name drugs with generics
- prescribing fewer drugs of limited clinical value (including cerebral and peripheral vasodilators and appetite suppressants)
- prescribing fewer modified-release preparations
- prescribing fewer benzodiazepines
- controlling the inappropriate rise in costs of selected newer and/or expensive drugs

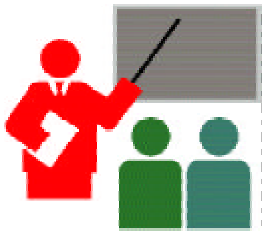
The findings suggest that the PSP practices have made relative savings in areas where it is believed that savings *can* be made without detriment to patients. In contrast, they have increased their costs in areas where it may be beneficial to patients e.g. lipid lowering drugs.

5.9 STANDARDS OF PROFESSIONAL PRACTICE

All healthcare professionals are required to comply with their own professional standards; for example the "Code of Ethics and Standards of Good Professional Practice" for pharmacists.

Those providing prescribing support ***must*** ensure that they are adequately covered by indemnity insurance. The practice will have no vicarious liability for the actions of a self-employed consultant. Existing insurance may only cover the "traditional" professional activities. Work undertaken in a GP practice will not be covered unless the insurers are specifically asked and agree to cover this service. Appropriate comprehensive insurance protection is a requirement of most healthcare professionals' code of ethics, including pharmacists.

5.10 TRAINING NEEDS OF THOSE OFFERING SERVICES



All professionals providing the services described above must be competent to do so. Having the skills to provide some aspects of prescribing support does not necessarily mean that they have the skills to do others. It is important to assess what skills are required, as part of the initial assessment of a practice's needs. The HA prescribing adviser can often give advice on this.

Training can improve the quality of advice given, increase the consistency of approaches, build confidence and develop further awareness of clinical issues. It is important that training programmes are geared towards services meeting the needs of prescribers. Practices or PCGs considering purchasing prescribing support should review the training needs of those providing it, both in advance of providing the service, and their ongoing training once they are working in practice.

Quite often HAs organise training for pharmacists giving prescribing advice. However it is not certain that HAs will be in a position to offer such training on a long-term basis. The CPPE provides pre-defined training free of charge to practising community pharmacists. Increasingly HAs and PCGs will need to consider whether they need to purchase training beyond that offered by CPPE or for pharmacists who are not practising in community pharmacy. They should liaise with their local education consortia, who will need to be aware of this new professional group and consider their training needs.

Current sources of training include:

- National Prescribing Centre
- Centre for Pharmacy Postgraduate Education
- College of Pharmacy Practice (CPP)
- UK Clinical Pharmacy Association (UKCPA)
- National Pharmaceutical Association (NPA)
- Regional Drug Information Services
- University pharmacy departments
- Community pharmacy companies
- Local hospitals
- Local Branch of the Royal Pharmaceutical Society of Great Britain
- Private pharmacy consultants
- Pharmaceutical Industry

From the many initiatives of this sort that are already in place, the following training needs have been identified (see appendix 2, page 95 to 96). Some pharmacists already have expertise in the majority of these areas, but specific training courses designed for pharmacists working with GP practices are invaluable in equipping them with all the essential baseline knowledge and skills:

- current issues in general practice prescribing
- interface issues
- GP computer systems and computer literacy
- general practice structure and procedures
- good repeat prescribing systems and the management of repeat prescriptions
- critical analysis, drug information and evaluating clinical papers
- PACT analysis, including use of electronic PACT systems
- therapeutics
- clinical case studies and interpreting clinical case notes
- formulary development
- optimum prescribing of new drugs
- meetings, communication and presentation skills
- negotiation and influencing skills, effective intervention approaches

It is not necessary to have undertaken a postgraduate qualification before providing these services. However, there are some very useful courses on offer (see appendix 9), which usually continue to Diploma, MSc or occasionally PhD level. Formal accreditation for practice pharmacists does not exist on a national level, although various HAs have introduced accreditation schemes for practice pharmacists working in their area. These tend to be based on attendance at training sessions rather than a fuller assessment of ability to do the job.

SUMMARY

Whilst prescribing support is not a new concept, the wide variety of services available has not been described fully before. The purpose of this guide is to make those with an interest in prescribing support aware of the sheer scope and range of potential services and how to go about commissioning them. It is hoped, by summarising the types of prescribing support that might be of value, together with the experiences of those who have already been involved in their development, that this guide will form a useful contribution to the management of prescribing in the New NHS.