

Health

Bulletin

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commission



Primary care prescribing

A bulletin for primary care trusts

The Audit Commission is an independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high-quality local and national services for the public. Our work covers local government, housing, health and criminal justice services.

As an independent watchdog, we provide important information on the quality of public services. As a driving force for improvement in those services, we provide practical recommendations and spread best practice. As an independent auditor, we monitor spending to ensure public services are good value for money.

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This Bulletin presents the findings of auditor's local work on prescribing in primary care, carried out in over 120 primary care trusts (PCTs) in England. It provides practical guidance for PCT board members, chief executives, directors of finance, prescribing advisers and GP leads, to help them get the most benefit for patients from prescribing budgets.

Why focus on primary care prescribing?

- 1 Government plans put primary care at the forefront of the drive to improve the NHS. By 2004, 75 per cent of the money that the NHS spends will be channelled through PCTs. PCTs are responsible for assessing, and commissioning for, the health needs of their population. This includes managing prescribing spending.
- 2 Primary care prescribing is costly – over £5.5 billion was spent last year – and these costs are rising rapidly. The Department of Health (DoH) takes forecasts of the likely drugs spend into account in determining overall allocations to PCTs. But with the many other competing demands for resources, PCTs are finding it very difficult to fund the growth in prescribing spending, and most are facing a significant funding gap. PCTs are keenly aware of the need to take action to address this situation, making now an appropriate time for us to publish our key findings.
- 3 This Bulletin summarises reviews of the management of prescribing completed by the Audit Commission in around 120 PCTs and groups over the past 18 months. The aim of these reviews is to highlight the common challenges associated with managing prescribing, in the context of the national increase in spending on drugs, and to use examples of good practice to illustrate how some PCTs are addressing them.

The national picture

- 4 An average PCT spends £18 million on prescribing, which is about 16 per cent of its total expenditure. This proportion is likely to rise as the anticipated growth in the drugs bill exceeds the general increases in NHS funding for 2002/03 [Table 1].

Table 1

Growth in spending on primary care prescribing compared to general increases in health spending

Past picture

Increase in primary care drugs spending – 1998/99 to 2001/02 ^I	29%
Increase in Family Health Services expenditure in same period ^{II}	21%

Future picture

2002/03 forecast increase in drugs spending ^I	11–13%
2002/03 planned increase in NHS spending ^{III}	8.8%

Source: see notes

^I Prescribing Support Unit (PSU) figures based on Prescription Pricing Authority data. The PSU is currently forecasting an increase of 11–13 per cent. The mid point of this range (12 per cent) has been used for the purposes of subsequent calculations in this Bulletin.

^{II} Department of Health, FID-RPA.

^{III} Department of Health, FID-RPA Departmental Report July 2002: Expenditure Plans 2002/03–2003/04.

Why is prescribing spending increasing so quickly?

- 5 In 2001/02, £540 million more was spent on prescribing than in 2000/01. Of this increase, almost one-half (£240 million) was accounted for by rises in just four of about 200 sections of the British National Formulary (BNF).
- 6 An analysis of last year's prescribing spend shows a sharp contrast between general drug inflation at 7 per cent, and a 25 per cent rise in some of the areas linked to national service frameworks (NSFs) – such as statins (drugs that lower blood cholesterol) and NICE guidance – such as on drugs for psychoses [Table 2].
- 7 As Table 2 shows, – the implementation of the Coronary Heart Disease NSF is the most significant factor driving the increases in drugs spending.

Table 2

Analysis of the £540 million increase in spending on drugs between 2000/01 and 2001/02

	Increase in spending on this section since 2000/01		Main reason for increase
	£m	%	
Lipid regulating (including statins)	103	33%	Coronary Heart Disease (CHD) NSF
Antihypertensives	59	18%	CHD NSF
Diabetes	49	23%	Diabetes NSF, NICE guidance and increase in numbers of patients diagnosed
Psychoses	39	32%	Availability of new class of antipsychotic drugs, reinforced by NICE guidance
Total increase for these four sections	250	25%	
Total increase for all other drugs (~200 sections)	290	7%	
Total increase in drugs spending	540	10.7%	

Source: Prescribing Support Unit data

What does this mean for PCTs?

- 8 On average, PCTs have increased their drugs budgets for 2002/03 by 10 per cent over the 2001/02 outturn, but early indications are that even this substantial increase will fall short of predicted spending.
- 9 Drugs costs are forecast to rise by around 12 per cent in 2002/03 – an increase of over £670 million. Even after the 10 per cent budget increase, this will leave over £110 million – an average of £360k per PCT – to be funded from other budgets. The rise in prescribing spending could bring a potentially serious finance and performance risk, impacting on PCTs' ability to stay within their resource limits and to properly fund other services unless they:
- identify and plan for the scale of increase in NSF and NICE priorities; and
 - ensure they secure best value from their prescribing spending overall.
- 10 These cost pressures seem set to continue over the next three years. DoH prescribing budget-setting guidance (for 2003/04 to 2005/06) advises that the current rate of increase (around 12 per cent for 2002/03) should be used as the starting point for any assessment of future growth.

How can PCTs deal with this?

- 11 This review was developed with the aim of helping PCTs in this difficult area, and was based on the premise that good management of prescribing is about more than containing costs. It is about improving the quality of prescribing by putting in place systems to ensure that drugs spending is targeted at patients who will benefit from the treatment, and that the most cost-effective treatment option is used without compromising patient care.

I feel like King Canute trying to stop the tide from coming in!

Prescribing Adviser for a PCT in the north of England

- 12 Controlling the increase in prescribing costs is a major challenge for PCTs, but there is scope to release money from within the drugs budget to fund some of the growth, by:
- managing the high-growth areas to ensure that spending is appropriately targeted on the patients who will benefit; and
 - realising savings from within the drugs budget.

Good management of prescribing also requires:

- effective strategic planning and performance management;
- mechanisms to influence prescribers, based on positive, open relationships with GPs and other professionals;

- appropriate direction of the efforts of the prescribing team, and evaluation of their impact; and
- close working with other PCTs and secondary care.

13 The remainder of this Bulletin sets out our findings in these areas, and gives practical examples of how PCTs have addressed specific problems.

Managing the increase in prescribing costs

High-growth areas

14 Effective prescribing is often more expensive. However, we found that some PCTs were not investigating growth in the use of drugs recommended in NSFs or NICE guidance. Increases in spending can disguise inappropriate targeting of scarce resources, and it cannot be assumed that a rise in spending in a particular area equates to an improvement in the quality of prescribing. To illustrate this, the issues around statins, resulting from the implementation of the CHD NSF, are explored below.

Impact of the Coronary Heart Disease NSF on prescribing

- 15 The highest growth area in recent years has been in statins – which are drugs that lower serum cholesterol. The Coronary Heart Disease NSF recommends that patients diagnosed with, or deemed to be at risk of, CHD should receive a number of interventions, including controlling high blood pressure and prescribing statins to reduce cholesterol levels.
- 16 The approach set out in the NSF was based on a model of high-quality care for patients, and it has to be implemented by all health bodies. In its recent review of trends affecting the health service the Wanless report concluded that statins offer value for money and made recommendations that would take expenditure to two or three times current levels. However, this has created cost pressures, illustrated in Table 2.
- 17 Prescribing of statins should be actively managed by PCTs and GPs to ensure that treatment is targeted at patients who can benefit the most. However, current evidence from medical research indicates that this is not always the case. Studies have found that:
- The rate of increase in the prescribing of these drugs (since 1999/2000) has varied widely between PCTs – from 43 per cent to 184 per cent – and there is no correlation between initial levels of prescribing of statins and the rate of increase.¹ This indicates differences in the pace of change.
 - A significant proportion (39 per cent in one study) of those taking statins are not in the high-risk group (as defined in the NSF), while large numbers of patients (up to 75 per cent of men who have suffered angina, and 66 per cent of men who have

¹ PSU data.

had heart attacks) who fit the profile of those likely to benefit from the drugs are not receiving them. These are mainly patients who were diagnosed five to ten years ago.^I

- Many patients (up to 75 per cent after two years) who are prescribed statins stop taking them.^I

What can PCTs do to ensure that spending is properly targeted?

18 PCTs and GPs need to ensure that patients receive high-quality treatment for CHD and, as part of this, appropriate prescribing of statins by:

- setting out treatment protocols for CHD that follow the principles of the NSF. The protocol should set out the checks (for example, of blood pressure and cholesterol) and information (for example, medical and family history) required, give guidance on how to assess the patients' risk of heart disease, and the actions to be taken dependent on the results;
- reinforcing the protocol through GP training events (which many PCTs are now funding);
- reviewing compliance with protocols through medical audit, clinical governance reviews, and support from the prescribing team;
- ensuring that systems are in place to identify existing patients (such as those diagnosed prior to the publication of the NSF) who are not receiving the currently recommended treatment. This may involve analysing medical records, updating practice registers and calling patients in to the surgery for reviews of their treatment;
- providing information leaflets for patients which explain how important it is for them to continue to take their medication; and
- ensuring that regular reviews of patient's treatment take place.

Setting up such systems can be time-consuming and difficult for individual practices. PCTs need to have support mechanisms in place to assist in this process, and a methodology for targeting this support at the appropriate practices.

19 This review found that systems such as the one set out above were poorly developed. This is understandable, as the CHD NSF is relatively new (published March 2000). However, it is vital that PCTs improve at actively managing this area, as there are indications that many more patients could be prescribed statins in the future. The results of a large clinical trial were recently published (the Medical Research Council/British Heart Foundation Heart Protection Study). This showed that a much wider range of patients than those included in earlier clinical trials could benefit from taking statins. The trial estimated that the number of people in this country taking these drugs could increase from 1 million to 3 million. This is some way off yet, but if the use of statins was extended as the trial indicates this would cost the NHS an extra £800 million (14 per cent of current drugs spending) per year.^{II}

I Based on various pieces of medical research. Summary provided and appraised by the National Prescribing Centre.

II This estimate is based on the cost of the drugs that are currently available. A number of developments are imminent in the market for cholesterol reducing drugs, which could have an influence on spending. One of the most commonly prescribed statins may become available in a generic form from 2003. If a cheaper version of this drug becomes available this could reduce spending. However, new lipid regulating drugs are expected to reach the market in 2003 and this may increase spending.

Realising savings

- 20 Building on its previous work, the Audit Commission has developed a national prescribing savings database in conjunction with the PSU [Box A]. The database estimates potential savings in a number of categories, for example, reducing spending on drugs considered to have limited clinical value,^I and ensuring that certain drugs known to be often over-prescribed, for example antibiotics and ulcer healing drugs, are only given where clinically necessary.
- 21 These savings have been calculated for every PCT in England. In total it is estimated that over £130 million (2.3 per cent of the drugs bill) nationally could be saved in the categories of drugs targeted in this database over the medium term. Table 3 shows the analysis of savings achievable for an average PCT that spends around £18 million on drugs.

Table 3
Summary of potential savings for an average PCT

Category of saving ^{II}	
Premium priced preparations	£62,000
Drugs of limited clinical value	£37,000
Drugs that are often over-prescribed (total of cost and volume savings)	
– Antibiotics	£59,000
– Oral non-steroidal anti-inflammatory drugs	£89,000
– Ulcer healing drugs	£183,000
Total potential savings for an average PCT	£430,000

Source: Audit Commission/PSU prescribing savings database

- 22 However, these average figures disguise very wide variation in potential savings between PCTs. For example, on 'cost savings for drugs that are often over-prescribed', the savings varied from 0 per cent to almost 2.5 per cent of expenditure on drugs [Exhibit 1].
- 23 These savings could not be realised in one year, so they cannot solve the immediate funding problem. However, they are important because it will be difficult to argue for large increases in funds if no progress has been made in achieving potential savings.

I As defined by the Audit Commission in its 1994 report *Towards Better Prescribing*.

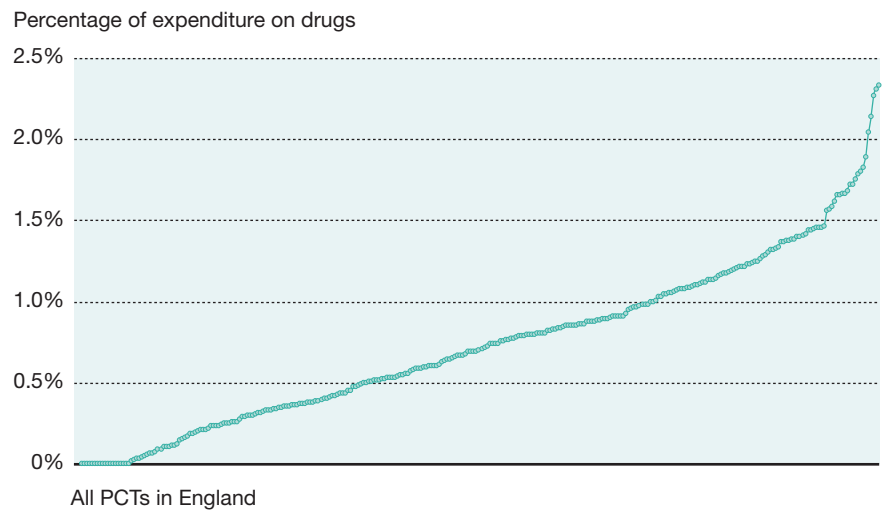
II These are a combination of cost and volume savings. Cost savings are calculated based on reducing spending per daily dose or per item to the level achieved by the best quartile of PCTs. Volume savings (an element of the 'Drugs often over-prescribed' savings) are calculated based on reducing the number of items prescribed per weighted patient to the median of all PCTs.

These are medium-term savings, unlikely to be realised in one year.

Exhibit 1

Potential cost savings on drugs that are often over-prescribed (as a percentage of expenditure on drugs) – for 2001/02

Prescribing savings vary considerably between PCTs.



Source: Audit Commission/PSU prescribing savings database

Box A

The Audit Commission/PSU savings database

This database has been used to support our work in PCTs and to provide them with some high-level performance information. It covers every PCT in England and includes:

- the potential savings in a number of categories – both in pounds and as a percentage of their spending on prescribing;
- the equivalent figures for the previous two years – enabling progress to be tracked; and
- comparison with all other PCTs for the current and previous two years, which allows PCTs to benchmark their position and to see how it has changed over time.

We have supported PCTs in using this information as performance indicators and to identify areas for further work.

A number of PCTs have incorporated the potential savings as medium-term targets in their performance management framework.

The database can help PCTs to put their own position into context, to focus their efforts, and to see the impact of their initiatives.

Box B

A Success Story

West Norfolk PCT has worked on reducing the amounts it spends on drugs that are often over-prescribed – particularly ulcer healing drugs. In two years they achieved almost all of the savings identified – saving £90,000 (0.5 per cent of their prescribing spend). They did this by switching some patients to a similar, but cheaper, ulcer healing drug, and by ensuring that patients were changed from healing (high) doses to maintenance (lower) doses of proton pump inhibitors (PPIs), as recommended in the NICE guidance.

The initiative started prior to our study, but the database enabled them to demonstrate the impact of their work – the fact that they had released £90,000 to invest in some of the growth areas of the drugs budget.

The Audit Commission report on prescribing within the PCT has reassured us that we are moving in the right direction in realising the potential savings in our drugs budget. It has helped us to identify areas to focus on this financial year.

Prescribing Adviser – West Norfolk PCT

Source: Audit Commission fieldwork

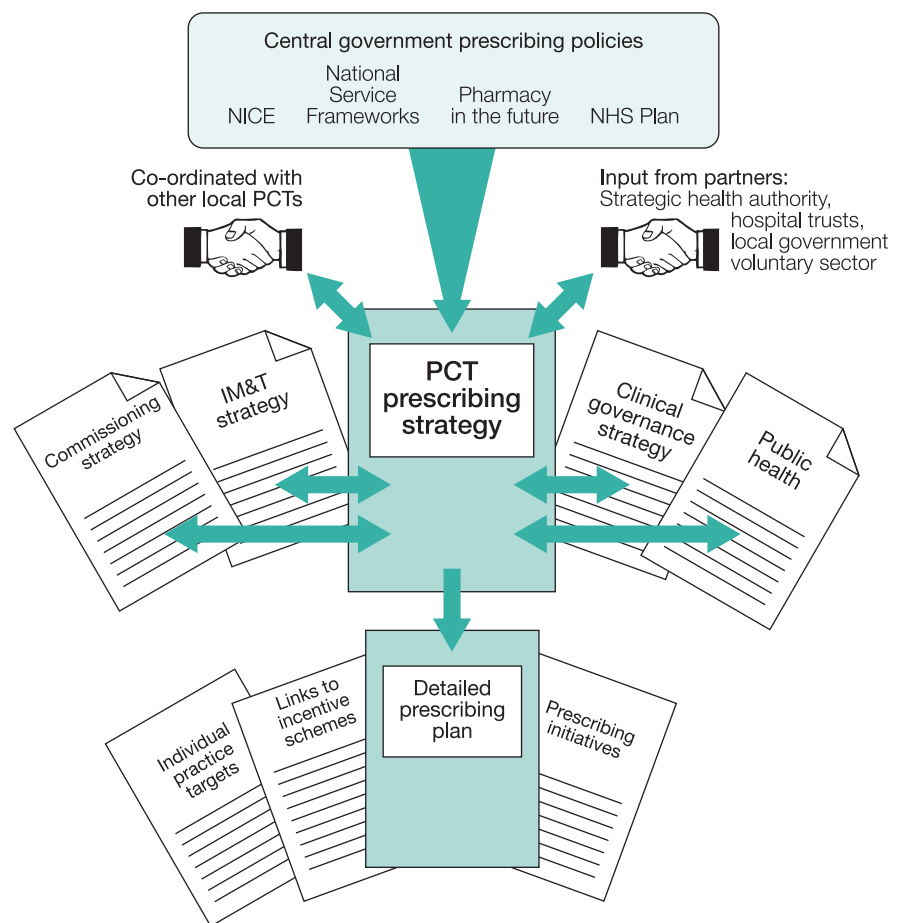
Strategy and planning

- 24 Good management of prescribing is crucial for maintaining the financial health of the PCT, so PCTs must have clear strategies, sound prescribing plans and systems to ensure that these are implemented.
- 25 Every NHS organisation has to take full account of its role in achieving national priorities for the NHS. They also have to incorporate local issues and involve other organisations in partnership arrangements. This is a complex process **[Exhibit 2]**.

Exhibit 2

Building a prescribing strategy

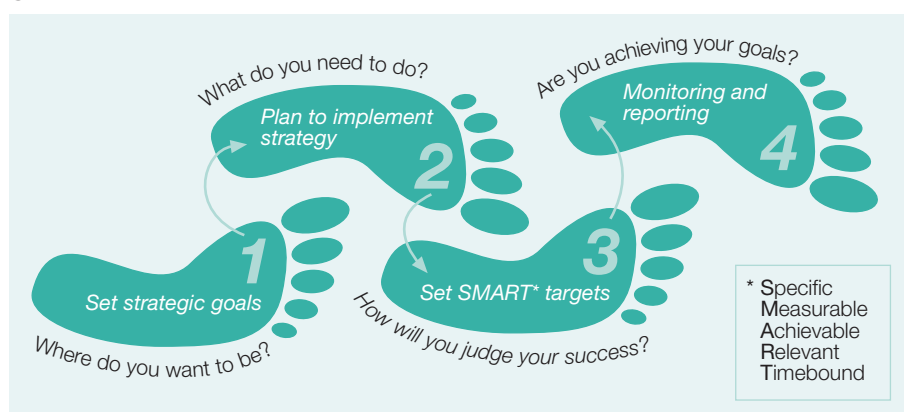
Developing a prescribing strategy that contributes to the achievement of national and local priorities is challenging and complex.



Source: Audit Commission

Exhibit 3

Our work reviewed four steps to achieving organisational goals



Source: Audit Commission

Setting strategic goals

- 26 Most of the PCTs we reviewed had a clear idea of where they were trying to get to in terms of prescribing, and most (although not all) had drafted a prescribing strategy document.
- 27 However, we found common weaknesses in the process. Strategic goals were often developed without an understanding of the current position, or any attempt to forecast the future. For example, information about areas of high growth and high spending was often lacking, as was the current and potential future impact of implementing NSFs. Strategic goals set without the appropriate information are almost bound to fail.

Developing a plan to implement strategy

- 28 Few PCTs had detailed plans to implement strategy. We assessed those plans that had been developed against a good practice checklist and found that the main issues were:
- poor links to other key plans within the PCT, such as the clinical governance, commissioning or IM&T plans;
 - whereas prescribing advisers typically had an excellent understanding of the local prescribing issues (such as levels of deprivation), this knowledge was often not exploited in the plans; and
 - the resources needed to implement the plan were rarely quantified – some plans were highly ambitious given the level of resources available; some were so vague that assessing the resources needed was not even possible.

Box C

Development of a planning cycle

In one of our earliest reviews, at Derwentside PCT, we recommended that strategies should include measurable targets for improving prescribing, and that these targets should be translated into realistic objectives and work programmes for pharmaceutical advisers.

The PCG then developed the following prescribing quality improvement cycle to give a structure to the work of the prescribing team.

January – April	<p>Planning including:</p> <ul style="list-style-type: none"> – budget setting; – determining targets based on NSFs and NICE guidance; and – designing an incentive scheme. <p>Lessons learned from previous years incorporated into each new year’s planning process.</p>
May – July	<p>Visit all practices to:</p> <ul style="list-style-type: none"> – feedback the results of last year’s incentive scheme; – set practice-specific targets linked to the PCT targets; and – identify those practices needing additional support to achieve targets.
July – November	Additional support provided to selected practices
December – January	<p>Results of initiatives evaluated</p> <p>Practice meetings booked</p>

The quality improvement cycle sets out our core work programme for the year. It helps us get back on track to our key objectives and we focus on doing the important things well. Since we drew up our quality improvement cycle, we’re a lot more organised. We plan more and there’s less of a mad rush to get things finished for a deadline. Everyone’s signed up to this. Now we’re clear about our priorities, and realise we can’t do everything, there’s a lot less pressure.

Prescribing Adviser – Derwentside PCT

Source: Audit Commission fieldwork

Setting SMART¹ targets

- 29 Incorporating well-designed, measurable targets into the plan is crucial to ensuring its delivery. The data on GP prescribing comes from a central source – the Prescription Pricing Authority (PPA) and it is one of the best data sets in the NHS. It is timely (available within six weeks of the end of each month), accurate, comparable and comprehensive. Setting measurable targets in healthcare is often difficult due to the complex nature of the decisions, but it should be easier for prescribing than for many other areas of spending due to the quality of the data available. However, target

¹ Specific, Measurable, Achievable, Relevant and Timebound.

setting was poorly developed in most of the PCTs that we reviewed. Some of the common problems we found included:

- long-term objectives being set without any interim steps or review points;
- vague objectives – for example ‘to reduce spending on drugs of limited clinical value’;
- incentive schemes with SMART targets which were applied to each practice individually – but there were no PCT-level targets linked to those in the incentive scheme; and
- poor use of data in performance management.

Box D

Getting SMART

As a result of our work, Doncaster Central redrafted their prescribing strategy and plan to incorporate the recommended good practice features. They identified a set of SMART targets that reflected:

- national targets;
- areas of potential savings identified in our work;
- quality prescribing; and
- NSFs.

Comparative graphs were compiled for each indicator. All practices were named. National, and family cluster averages (of demographically similar PCTs) were plotted, as was the PCT target position. These were then used as the basis for agreeing a practice development and performance agreement with each practice, focusing the efforts of each practice on the areas where most improvement is needed. Achievable targets were negotiated with each practice. The process is designed so that if each practice meets its own targets, the PCT will meet its corporate objectives on prescribing.

Source: Audit Commission fieldwork

Box E

...and not so SMART

Examples of imprecise – not SMART – targets from a number of PCT plans:

- To continue to reduce the number of antibiotic items prescribed and reduce the use of second-line antibiotics.
- To encourage the implementation of NICE guidance on PPIs.
- To disinvest in drugs of limited clinical value.

Source: Audit Commission fieldwork

Developing monitoring and reporting systems

- 30 Most PCTs have a system of regularly reporting prescribing issues to the PCT Board and to the Professional Executive Committee. However, reports and discussions are often limited to financial performance against budget.
- 31 Prescribing is a complex and specialised area and is often treated as a separately managed area within the PCT. Prescribing reports can be full of technical terms, which makes them difficult for someone without pharmaceutical knowledge to interpret. There is, in some PCTs, a lack of a common vocabulary between finance officers and prescribing teams. This can result in poor decision making **[Box F]**.
- 32 Reports on prescribing need to incorporate more than just the financial issues, and they should be written in clear language, with the implications of the reports clearly articulated.

Box F

When prescribing and finance don't communicate

The Audit Commission/PSU savings database was presented to a PCG in the south of England. As a result, it was proposed that the following year's prescribing budget should be cut by the amount of the potential savings. This took no account of the other growing pressures on the drugs budget and demonstrated a lack of understanding between finance and prescribing staff of the issues that each were facing.

The need to resolve this issue resulted in a better understanding on both sides, and a more realistic budget was set, but this example illustrates the lack of awareness that can exist.

Source: Audit Commission fieldwork

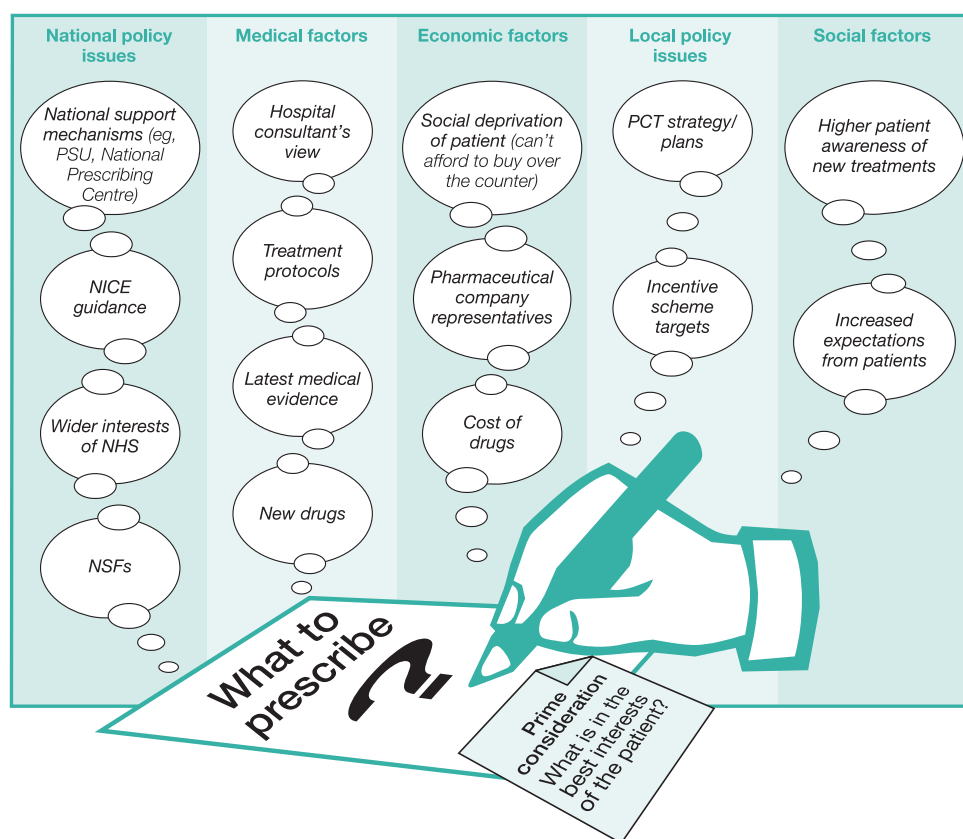
Influencing prescribers

- 33 A key challenge for PCTs is to effectively influence prescribers, as PCTs do not directly control the levers for change. The drugs budget is spent predominately by GPs, who (apart from some on personal medical services contracts) are not employed by PCTs. The total spend is the sum of all the prescribing decisions they make in individual consultations with patients. These decisions are influenced by many factors **[Exhibit 4, overleaf]**.
- 34 If a hospital trust is faced with financial difficulties, a range of, albeit undesirable, options are open to it, such as cancelling routine surgery or freezing recruitment. When faced with an overspending drugs budget, PCTs have no such direct levers to curtail spending.

Exhibit 4

Factors influencing prescribing

Many factors influence a GPs decision on what to prescribe to a patient.



Source: Audit Commission

35 Given this complex picture, PCTs must adopt a robust and proactive stance in promoting their strategic goals for prescribing. A number of components are needed to achieve this:

- strong leadership with consistent messages from the PCT;
- an effective GP prescribing lead;
- open sharing of performance data; and
- a well-designed incentive scheme.

36 Many factors can influence a prescribing decision and it is impossible in the time available for a GP to consider them all. To ensure that the factors uppermost in a GP's mind match the goals of the PCT, there is a need to align these aims with as many of the factors as possible. For example, one of the goals of the PCT should be to implement the NICE guidance on PPIs, which are widely prescribed for all types of dyspepsia, as this represents the most appropriate treatment and would reduce costs. The prescribing implications of this guidance should be assessed and reinforced through GP training,

the development of treatment protocols and through building a consistent approach between GPs and hospital consultants.

- 37 Where external influences, such as patient expectations or pressure from pharmaceutical company representatives, are counter to the goals of the PCT, a strong line should be taken. This could involve:
- giving GPs advice on how to deal with the pressure from patients;
 - encouraging practices to set down strict guidelines on dealing with pharmaceutical companies (following the DoH guidelines on commercial sponsorship);
 - developing treatment protocols, incorporating best medical and prescribing practice, backed by training and support [Box G]; and
 - providing training for GPs in critical appraisal of clinical trials and reviews.

Box G

Incorporating prescribing advice into GP training

Four Bradford PCTs jointly fund a PACE (Promoting Action on Clinical Effectiveness) programme. This is a system of developing evidence-based treatment guidelines on a small number of key topics each year. The guidelines are developed by a consensus group, which includes GPs, pharmacists, hospital consultants, nurses, social services and patient representatives.

The GPs and other practice-attached staff are given locum funding to enable them to attend education events based on the guideline. Attendance is very high, with at least three representatives from every practice.

Delegates are provided with a pack including the treatment protocol on two sides of laminated A5, along with extensive background information. An audit is also developed based on the guideline, and assistance or funding is provided to practices to enable them to carry out the audits.

Prescribing guidance is incorporated into the treatment guideline. To date, guidelines have been developed for a number of areas where prescribing plays a key role in appropriate treatment, for example, diabetes, psychosis and heart failure.

The PACE goals include:

- building teamwork with other members of the practice team;
- developing experience of action planning;
- reaching agreement to share audit data, action plans and ideas with other practices and with the PCT; and
- enhancing knowledge of best clinical practice based on the latest medical evidence.

PACE will be evaluated through re-audit of the guidelines and other techniques. For example, prescribing guidance may be monitored through PMS contracts in some PCTs. The first evaluation is planned soon.

Source: Audit Commission fieldwork

Box H

Adopting a robust stance on inappropriate prescribing

East Yorkshire PCT decided to take a strong line on inappropriate prescribing. This is an extract from their strategy document:

The PCT will work closely and in co-operation with all prescribers to ensure prescribing is in line with good practice. Where prescribing is giving cause for concern, the PCT will support the prescriber in reviewing prescribing trends to assess whether prescribing is appropriate.

- *the pharmaceutical adviser will discuss the area of concern during routine visits with the prescriber; and*
- *the pharmaceutical adviser will arrange a further visit in conjunction with the clinical governance lead and prescribing lead from the executive committee.*

If agreement is still not reached, the prescriber will be encouraged to audit the area of concern, and will be given the support of a practice pharmacist and audit person to facilitate this, if appropriate and required.

Where the audit shows persistent inappropriate prescribing and the prescriber resists change the matter will be referred to the appropriate health authority adviser¹ for further action, which may result in the use of the revalidation procedure for GPs, or other appropriate mechanisms for other prescribers¹.

Because the PCT has a positive relationship with its GPs, this sanction has never had to be invoked.

Source: Audit Commission

Box I

Adopting a robust stance on working with commercial organisations

Amber Valley PCT has developed an effective policy for working with the pharmaceutical industry. Part one of the policy applies to those independent contractors who have PMS contracts and contains principles for collaborative working. It includes additional principles on the use of new drugs, appliances and dressings. Staff are directed to discuss issues with the Prescribing Adviser and Clinical Governance Adviser. Procedures for sponsorship are included in the policy, and all agreements are subject to monitoring and evaluation.

Part two applies to all independent contractors and includes guidance on drawing up practice policies.

As a result of this policy pharmaceutical company representatives are routed via the information office, and few GPs now receive these representatives directly.

Source: Audit Commission

¹ Wording is currently being revised to take account of the health authorities' demise.

Effective GP prescribing lead

- 38 A committed and credible GP prescribing lead is key to building positive relationships between the PCT and GPs. This is a new and developing role so it is understandable that this review found considerable variation.
- 39 It is crucial that each PCT is clear about the role that they want the GP lead to fulfil. This was not always the case. As part of this work we carried out a survey **[Box J]** which gathered data on current practice, and staffing levels from 65 PCTs. This survey showed that only one in four GP leads have a written job description.

Box J

Audit Commission survey of PCTs

Responding to requests from prescribing advisers, we identified a number of areas where comparative data would be useful to help PCTs put some of their decisions and policies into a broader context. This included:

- staffing levels and staff mix in prescribing teams;
- access to support staff, that is, data analysts, admin support;
- policy on sharing data;
- the role of the GP lead; and
- design of, and investment in, incentive schemes.

A survey was developed to gather the data, which was distributed to PCTs where prescribing work had been carried out. We had 65 responses between August and November 2002. The PCTs that participated have received a data pack showing where they appear in the comparisons. The results of this survey have been extensively used in this Bulletin.

More PCTs will be added to the database as our new prescribing study is rolled out during 2003.

Source: Audit Commission fieldwork

- 40 As one of the key roles of the GP lead is to promote good prescribing among colleagues, accompanying the prescribing adviser (PA) to some of the more difficult practice meetings would seem appropriate. But our survey indicated that one in three GP leads never attend practice visits.

Box K

The benefits of an effective GP lead

The GP lead at Amber Valley PCT has been involved in promoting good prescribing practice to other GPs for a number of years. He has credibility and a well-established reputation among colleagues. His role includes:

- visiting overspending practices and exerting influence via peer pressure;
- accompanying PCT executives on prescribing budget ‘roadshows’; and
- developing good communication between finance staff, GPs and the Prescribing Adviser.

The strong role taken by the GP lead has contributed to an open, constructive relationship between the GPs and the PCT. Data is openly shared, prescribing advice is valued and prescribing savings are low (in the best quartile nationally¹).

Source: Audit Commission fieldwork

Sharing performance information

- 41 One of the most powerful, and simple, methods of promoting good prescribing is to introduce the open sharing of comparative data on prescribing. The use of performance data is growing in the medical profession. When this work began in 1999, very few primary care groups were naming all practices on comparisons of prescribing indicators, but the latest figures from our survey show that 75 per cent of PCTs are now using this approach.
- 42 The most common reason cited by PCTs for not sharing information is reluctance among GPs. Concerns are certainly understandable and some PCTs have had to show strong leadership in winning GPs’ support for open publication. Perhaps the knowledge that most GPs in England have accepted sharing data as a necessary part of the drive to improve standards will encourage those who are still reticent.

Incentive schemes

- 43 Incentive schemes are the main mechanism by which the goals of the PCT are made meaningful at practice level, so it is important that they are designed to reward rational prescribing and work towards achieving the PCT’s strategic goals.
- 44 Almost all PCTs have a prescribing incentive scheme, as required under DoH rules. This review assessed incentive schemes against good practice criteria – **Table 4** summarises our general findings.

Table 4
Incentive scheme findings

Good practice criteria ¹	General findings
<i>Scheme design</i>	
There is a balance between targets to improve quality and cost-effectiveness.	Most schemes had a good range of targets.
Targets are designed so that improvement is rewarded – in order to motivate even poorly performing practices.	This varied considerably. We found examples of very tailored schemes, which provided practices with individual targets based on their current performance, and very rigid ones, which used the same targets for every practice.
A flexible interpretation of the DoH requirement that an improvement in financial performance is necessary to achieve a payment.	<p>In the current climate of high growth in drugs spending, a simple requirement to stay within budget or underspend by less than the previous year is extremely difficult for most practices to achieve. However, this is how the majority of PCTs (75 per cent in our survey) have interpreted the DoH guidance.</p> <p>If this definition is used, forecast overspends can make the incentive scheme meaningless within weeks of the start of the year. This has, in some PCTs, led to the virtual abandonment of the scheme. As a result, the non-financial targets are not achieved.</p> <p>The survey showed that just one-quarter of PCTs used other, more specific criteria (for example, achievement of savings in specific areas) to meet the financial requirement of the scheme.</p>
<i>Integration with overall performance management framework</i>	
Targets reflect the priorities of the PCT	This was generally true, but some PCTs were found where big issues or areas of high potential savings were not covered in their scheme.
Targets in the scheme are monitored for the whole PCT as well as for individual practices, so that the overall impact of the scheme can be assessed.	Very few PCTs have evaluated the impact of the scheme on their overall performance, or incorporated global PCT targets that match those in the incentive scheme into their prescribing plan. This makes judging the effectiveness of incentive schemes as a method of delivering real improvements very difficult.

¹ The good practice guidance was developed by Audit Commission, drawing on earlier Audit Commission and DoH recommendations and on findings from study sites.

Good practice criteria**General findings****Balance of scheme**

Schemes need to get the balance right between the level of difficulty, and the amount of reward. This motivates practices to participate, while ensuring that the benefits outweigh the costs. While variation is inevitable, the information provided by our survey should help PCTs to make more-informed decisions about the design of their scheme.

Level of difficulty. The scheme is challenging, but achievable for most practices.

Many PCTs are struggling to get this balance right. Our survey showed that in 20 per cent of PCTs, three out of five practices received no payment, implying a fairly challenging scheme, and/or a low number of practices participating in the scheme.

By contrast, in 33 per cent of PCTs, **all** practices were successful, implying that the targets may not be sufficiently challenging.

Amount of reward. Payments are sufficient to motivate change, but not out of proportion with likely savings/benefits.

We found wide variation in the level of investment in incentive schemes. Total amounts paid out varied from 0.05 per cent to 1.7 per cent of the drugs bill.

The size of payments made to each successful GP ranged from £300 to £5,000.

Support and information for practices

Regular feedback is given during the year to allow progress to be monitored.

In many PCTs, in-year feedback on performance against the targets in the scheme was not provided. Our survey results confirmed that almost one-third of PCTs were only giving feedback at the end of the year.

Support is available to help practices to achieve change.

Some level of practical support (such as assistance with repeat prescribing audits, reviews of patients' records, and so on) was available in most PCTs.

Source: Audit Commission fieldwork and results from the survey of PCTs

Effective prescribing teams

- 45 As PCTs have taken over the management of the drugs budget, the number of pharmacists providing prescribing support to GPs has increased dramatically from around 150 in 1998 to an estimated 600 plus in April 2002.¹ This represents a very large increase in investment in prescribing advice.
- 46 Most PCTs have developed multidisciplinary teams to manage prescribing, including pharmacists, data analysts and administrative support. The size of these prescribing teams and the mix of staff used varies widely. In our survey the range was from one full-time equivalent between every three practices, to one between 30.
- 47 There is no 'correct' size or mix, but the PCTs in this survey now have some benchmarking data that can inform their discussions on whether their staffing levels are appropriate to their specific circumstances and objectives.

¹ Full time equivalents – extrapolated from the results of our survey of PCTs.

- 48 The impact of this increase in investment is difficult to assess. However, we found two key factors that influence the benefits of prescribing support. These were around:
- organising the team to maximise the time spent working with GPs and practices; and
 - evaluating the impact of initiatives.

Targeting of effort

- 49 Experience has shown that face-to-face contact with GPs (and other prescribers), for example, through practice visits, and working directly with practices to improve prescribing, are the most effective methods of delivering change [Box L]. Prescribing advisers need to organise their work in a way that maximises the amount of time they can spend doing these things.
- 50 Some advisers are becoming involved in tasks such as data analysis and administration. This is a poor use of their skills. Our survey found that over 50 per cent of advisers had no access to dedicated data analyst support, and that 38 per cent had no administrative support. Other PAs had a different problem: they were spending a lot of time on high-level tasks such as strategy development and developing complex budget-setting methodologies, rather than sharing approaches with other PCTs or using the budget-setting utility on the PSU website. The efforts of the prescribing team need to be directed towards those actions that demonstrably lead to change.

Box L

Empowering prescribing advisers

The Commission's work at Newark and Sherwood PCT identified several issues for the Trust to consider in order to strengthen its management of prescribing. These included:

- exposing the extreme pressure placed on the current prescribing resource and the lack of a model for the operation of the prescribing team; and
- recommending strengthening reporting arrangements and raising the profile of prescribing within the PCT.

When follow-up work was carried out, the results showed that:

The PCT has made significant changes to the management of prescribing since our review, culminating in strong visible leadership in prescribing within the PCT. The PA is well supported and appears to be better integrated into PCT mechanisms – enabling her to more effectively influence medicines management in the short and long term.

The Prescribing Adviser commented that:

The Audit Commission has supported the PCT through some tremendous changes – giving confidence and support in a difficult journey. I feel noticed and an equal within the PCT now.

Source: Audit Commission fieldwork

Impact evaluation

- 51 We have seen many examples of innovative initiatives designed to improve quality and cost effectiveness. But the impact of the increased investment in prescribing support is difficult to judge, as very few PCTs have evaluated the work of their prescribing team.
- 52 Evaluation can be time-consuming, but it has a number of benefits [Box M]. It:
- provides evidence of what works and what does not, allowing initiatives to be adapted;
 - demonstrates the value of prescribing support;
 - can be used to judge the achievement of objectives; and
 - is motivating for GPs and the prescribing team to see the success of their hard work.

Box M

The benefits of understanding the impact of prescribing support

The Prescribing Adviser at Mansfield PCT carried out a brief evaluation of the work of her team over a six-month period in response to a challenge to demonstrate the benefits of prescribing support. This identified a minimum of £120,000 of savings achieved through a combination of work at individual practices and PCT-wide initiatives.

Financial impact of Prescribing Team Jan–July 2001

*Financial savings of at least £122K have been identified**

Key prescribing area	Cost reduction per year
Proton pump inhibitors	3 practices: £22,000
Premium price preparations:	
• modified release nitrate preparations	6 practices: £18,000
• modified release NSAIDs	1 practice: £6,000
• modified release diltiazam	4 practices: £5,000
Appliance usage	4 practices: £26,000
Generic preparations	PCT basis: £22,000
Drugs of limited clinical value	PCT basis: £15,000
Effervescent analgesia	3 practices: £8,000
Total	£122,000

**The report recognises this to be a significant underestimate.*

The Prescribing Team work routinely in 11 out of the 16 practices offering a dedicated half-day support. In addition they have:

- carried out follow-up work on previous repeat prescribing reviews;

- set up CHD risk registers;
- carried out ad hoc pieces of work in all but one of the practices; and
- supported the development of practice formularies across all practices in the PCT.

The report clearly illustrated that financial savings can be achieved when prescribing support is provided to practices.

Source: *Audit Commission fieldwork*

Joint working with other PCTs

- 53 Most PCT prescribing advisers are meeting their local colleagues regularly and sharing information. There are also examples of workload sharing – for example, attendance at a local trust’s drugs and therapeutic committee was being rotated around its PCTs.
- 54 However, sharing approaches that can save time and improve standards are more rare. There are many areas where it can be useful, such as development of strategy and plans, design of incentive schemes or identifying successful initiatives that others could adopt.

Box N

Sharing approaches saves time

The prescribing strategies and plans of PCTs in a large metropolitan area showed a wide variation in structure, content and selection of objectives. The PAs had each drafted their strategy documents, without any discussion with their colleagues. They had, in fact, never seen each other’s planning documents. Yet they met weekly, and the GP leads attended once a month.

The PAs agreed that they were facing a similar set of issues. The Commission suggested that they use one of their regular meetings as a strategy/planning workshop where they can discuss their approaches, learn from each other, and possibly agree on a core set of objectives. This approach still allows for local flexibility, but enables organisations to learn from each other. They have agreed to do this in their next planning round.

Source: *Audit Commission fieldwork*

Box O

Avoiding duplication of effort

The PCTs in the old South Derby HA area have jointly funded a health-economy-wide pharmacist information officer. This role includes compiling and disseminating information, for example, on new drugs, supporting the Area Prescribing Committee, providing a central support role to PCT PAs and acting as a help desk for queries. They are also responsible for horizon scanning and forecasting trends in drug spend across the health economy. The role has been precisely specified to ensure clarity around the responsibilities of this post and the PAs for the PCTs.

The appointment of this role has significantly reduced duplication of effort. This has allowed PCT PAs to concentrate on activities that deliver real change, specifically supporting their practices, and building relationships with GPs.

Source: Audit Commission fieldwork

Relationship with secondary care

- 55 The drugs policy of local trusts and the prescribing decisions of consultants are crucial influences on primary care prescribing. Systems should be in place to ensure that each sector takes account of the impact that their decisions have on the other.
- 56 The main mechanisms for managing the primary/secondary care interface are:
- drugs and therapeutic committees (D&TCs) at each Trust – attended by primary care representatives;
 - area prescribing committees (APCs) – with representatives from the whole health economy. The role of this body is to co-ordinate drugs policy, for example, by managing the introduction of new drugs; and
 - shared care protocols – these should be developed for more specialised drugs, to clarify the responsibilities of the GP and the consultant.
- 57 Relationships with secondary care were found to be in a state of flux in most areas, as health authorities (HAs) disbanded and PCTs had to develop their own links with Trusts. As a result there was a very mixed picture, which included:
- many D&TCs and APCs in the process of being reconstituted to incorporate PCT representatives;
 - various approaches to primary care representation on D&TCs and APCs, with every PCT having a representative on these groups in some health economies, and others agreeing to rotate attendance, or nominate one representative;
 - progress stalled in some areas on the development of shared care protocols; and

- some problems filling the gap left by the HA prescribing advisers on health-economy-wide issues. In some areas PCT PAs were sharing the workload, others (30 per cent of those responding to our survey) have pooled resources to employ a health-economy-wide post. Where individual PCT PAs had taken on these roles we found some duplication of effort, for example, in the assessment of new drugs.

Future work on prescribing

58 The Commission's prescribing review is currently being expanded and updated to address some of the key risk areas, such as:

- the impact of NSFs;
- the implementation of *Pharmacy in the Future*;
- development of the role of the community pharmacist and nurse prescriber; and
- medicines management.

The work will be supported by:

- an improved prescribing cost drivers database (including indicators on growth areas and potential savings); and
- a database, building on the current survey of 65 PCTs, providing other benchmarking data (for example, on investment in incentive schemes, levels of staffing in the prescribing team, role of GP lead); and
- examples of good practice identified in our work to date.

The revised *Prescribing in Primary Care Trusts* product will be available in summer 2003.

The Audit Commission is developing a study on general practice, which will consider prescribing in the context of the overall use of resources. An audit and publications for PCTs are expected during 2003.

A PCT study is also planned for 2003.

If you would like more information, or are interested in knowing more about anything you have read in this Bulletin, please contact your District Auditor or local audit manager, ring our Business Development Directorate on 0121 224 1114, or email prescribing@audit-commission.gov.uk.

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