

An exploration of the potential impact of primary care groups on pharmaceutical practice

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AIM • To describe the management of prescribing within primary care groups (PCGs) and to explore the potential impact of PCGs on pharmaceutical practice.

DESIGN • Self-completion questionnaires and face-to-face interviews.

SUBJECTS AND SETTING • Board members of a stratified, random sample of 53 PCGs in England.

RESULTS • 40 PCGs (94%) had set up prescribing subgroups and 23 (44%) had community pharmacists as members of these groups.

Pharmacists were providing prescribing advice to 45 PCGs (87%); 17 of these (38%) were employing sessional community pharmacists. The most common source of funding for the pharmaceutical advice was

“top slicing” the prescribing budget. Prescribing targets and priorities commonly reflected a combination of national priorities and a local desire to make cost savings on some specific areas of prescribing. Medicines management and better use of community pharmacists were identified by many board members as key areas for development.

CONCLUSION • Most PCGs had made significant progress in developing policy and practice to manage their prescribing costs. The increasing involvement of pharmacists in prescribing policy, particularly those from community practice, reflects a commitment to a multidisciplinary approach to medicines management in primary care. One of the key challenges for the future will be to achieve the right balance between cost constraints and quality of prescribing.

Health authorities have had systems in place to monitor prescribing for a number of years and these have been used by pharmaceutical and medical advisers to develop and implement strategies to influence general practitioner (GP) prescribing. The inception of primary care groups (PCGs) in England has started to shift this responsibility away from health authorities. Consequently, PCGs and trusts (PCTs) are now faced with the challenges of managing their own cash-limited budgets while simultaneously delivering on their quality agenda. In the area of prescribing, these challenges are coming into sharp focus through both the national service frameworks (NSFs) and the guidance which will be increasingly forthcoming from the National Institute for Clinical Excellence (NICE). The first two NSFs cover mental health and coronary heart disease (CHD), both areas where increased prescribing may be needed if the quality of patient care is to be improved. The results of two recent surveys^{1,2} clearly show that the development of prescribing advice to PCGs provides an important opportunity for greater numbers of pharmacists to use and develop their skills. Within the new National Health Service (NHS), there are also tremendous opportunities for pharmacists to get involved in the wider quality agenda through clinical governance.³

In March 1999, the Department of Health commissioned the National Primary Care Research and Development Centre and the King's Fund to undertake a longitudinal (tracker) survey of a representative sample of PCGs in order to support the de-

velopment of PCGs and inform policy development and implementation.⁴ In the first year, the tracker survey has concentrated on describing how PCGs are approaching their functions, their priorities for service development and their goals for the future. The aims of this paper are to describe how prescribing is being managed within PCGs and to explore the potential impact of PCGs on pharmaceutical practice.

METHOD

The tracker survey is based on a 15 per cent (n=72) random sample of all PCGs in England, stratified by NHS region. Data were collected through face-to-face interviews with PCG chief officers, PCG chairmen and health authority leads. After piloting, self-completion postal questionnaires were sent to prescribing leads, clinical governance leads, information management and technology leads, social services board members, two GP board members, two nurse board members and the lay board member. Data were collected between September and December, 1999. The data presented in this paper are largely from the prescribing lead questionnaire, but also draw on data on a wide variety of issues, including:

- Composition of prescribing committees
- Level and funding of pharmaceutical support
- Influences on the development of prescribing targets
- Use of prescribing information
- Managing the entry of new and high-cost drugs
- Use of formularies and guidelines
- Achievements and future aspirations

The questionnaires comprised a mixture of closed and open questions. Quantitative data were entered into SPSS for Windows (version 9) and responses to open questions were entered into a text file before thematic analysis.

RESULTS

After one reminder, completed questionnaires were received from 52 prescribing leads (72 per cent). Of these prescribing leads, 49 (94 per cent) were GPs, two had a background in public health and one was a pharmacist. All except three prescribing leads were members of the PCG board and all except one had been on the board for at least six months.

Processes to improve prescribing District or area prescribing committees were in existence within 48 of the PCG localities (92 per cent) in this survey. Their composition reflected both the strong involvement of secondary care and the continuing influence of health authority pharmaceutical and medical advisers at this level (Table 1).

Forty-nine (94 per cent) of the PCGs

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TABLE 1: COMPOSITION OF PRIMARY CARE GROUPS PRESCRIBING SUBGROUPS AND AREA/DISTRICT PRESCRIBING COMMITTEES (N=52)

Member	Prescribing subgroup	Area committee
PCG pharmacist	33	25
Health authority pharmaceutical adviser	30	43
Health authority medical adviser	5	33
Hospital pharmacist	10	39
Hospital consultant	2	33
Community pharmacist	23	13

TABLE 2: PROVISION OF PRESCRIBING ADVICE TO PRIMARY CARE GROUPS

Type of prescribing advice	No of PCGs
PCG prescribing advisers only	25
Sessional community pharmacists only	10
Both PCG prescribing advisers and sessional community pharmacists	10
None	7

had set up their own prescribing subgroups and the composition of these, compared to the district committees, show less engagement with the health authority advisers (Table 1).

Community pharmacists were members of 23 prescribing subgroups (44 per cent) and 13 district or area prescribing committees (27 per cent).

The level of pharmaceutical prescribing support available to each PCG varied considerably with seven having no support at all (Table 2). In total, 108 pharmacists were providing prescribing advice to 45 (63 per cent) of the PCGs. The maximum level of support identified was one PCG with two full-time pharmacists and one with one full-time as 12 sessional community pharmacists. The most common source of funding for pharmaceutical advice was "top slicing" the prescribing budget (26 PCGs; 50 per cent). The other main funding sources were management budgets (18 PCGs; 35 per cent), and central health authority budgets (13 PCGs; 25 per cent). In order to get a broader view of how pharmaceutical expertise can be used within PCGs, clinical governance leads were asked about their current and future plans for using community pharmacists to deliver their clinical governance agenda. The most commonly identified areas were formulary development and repeat prescribing schemes (Table 3).

Prescribing priorities When asked about the influences on the process of determining prescribing policies and targets for the PCG, the prescribing subgroup was identified as the greatest influence on a 1 to 5 scale from "no influence" to "great influence". Thirty respondents (75 per cent) rated the prescribing subgroup influence as either 4 or 5 on the scale. There were no clear differences between the perceived influences of national policy, the NICE, the health authority and the PCG board.

Prescribing targets were linked to incentive schemes in 41 PCGs (79 per cent), to clinical governance targets in 21 (40 per cent) and to health improvement programmes in 19 (36 per cent). The most common prescribing targets were improving generic prescribing rates (35 PCGs; 67 per cent), reducing antibiotic prescribing (22 PCGs; 42 per cent), rationalising the prescribing of proton pump inhibitors (17 PCGs; 33 per cent), improving the management of coronary heart disease (16 PCGs; 31 per cent), achieving budgetary targets (10 PCGs; 19 per cent) and improving repeat prescribing systems (nine PCGs; 17 per cent).

TABLE 3: USING COMMUNITY PHARMACISTS IN CLINICAL GOVERNANCE

Area	Currently involving community pharmacists		Planning to involve community pharmacists	
	No	%	No	%
Formulary development	17	33	16	31
Repeat prescribing schemes	16	31	15	29
Chronic disease management	6	12	7	13
Health promotion	4	8	9	17
Management of minor ailments	3	6	12	23
Deliver aims of health improvement plan	3	6	11	21

Monitoring and improving prescribing Of the PCGs, 49 (94 per cent) used prescribing indicators based on prescribing analysis and cost (PACT) data to monitor prescribing by individual practices. Almost half of these (21 PCGs; 43 per cent) were using the electronic version, ePACT, but only 13 (26 per cent) were using the prescribing toolkit. (The prescribing toolkit is a set of measuring tools for the purpose of analysing Prescription Pricing Authority data. The data are presented in the form of a set of national user-defined standard reports.) Forty-nine PCGs (94 per cent) used PACT data to identify poorly performing practices and in 29 of these (58 per cent) unanonymised prescribing data were shared among practices.

Twenty-five PCGs (48 per cent) were planning to produce a formulary and for most this would be under the auspices of the prescribing subgroup rather than the wider district or area communities. However, 20 were planning to involve the local secondary care trust in this process. Only seven were planning a comprehensive formulary, most aimed at targeting specific therapeutic groups. Thirty PCGs (58 per cent) were planning to introduce prescribing guidelines. In line with the stated prescribing and clinical governance priorities, the areas most likely to be targeted for guideline development were antibiotics, gastrointestinal disease and coronary heart disease. However, a wide range of other guidelines were planned or were in operation in many PCGs. Only six PCGs (14 per cent) were planning to set up their own systems for managing the entry of new and expensive drugs and 38 (73 per cent) were approaching the problem on a larger scale through the district or area prescribing committee, or were relying on guidance from health authorities.

Achievements From responses to the open question, "What have been the most significant achievements of the PCG to date in terms of prescribing?", several recurring themes were identified. Not surprisingly, for some respondents their key achievements were the setting up of incentive schemes.

Another theme was the enhanced co-operation between general practices and the sharing of anonymised prescribing data: "Developing relationships and openness among practices, including data sharing."

For others, a key achievement was the appointment of a pharmaceutical adviser: "Without our local prescribing adviser/pharmacist it would be impossible to achieve anything. It is essential to provide continued support for the employment of pharmacists in this capacity."

When asked to indicate whether the PCG had impacted on specific areas of health care, PCG chairmen and GP board members identified prescribing as the area in which most impact had been made, followed by disease prevention and health promotion.

The future When asked what were the key tasks for the PCG over the next few years in relation to prescribing, respondents expressed great diversity in their opinions, ranging from "a hopeless task" to "we have a strong strategy and given time we will make great gains". The most frequently identified prescribing tasks for the next year related to remaining within budget and achieving incentives. However, others perceived that they now had opportunities to improve the quality of prescribing rather than focusing exclusively on cost. This desire to focus more on improving the quality of prescribing also identified a tension: "Extremely difficult to achieve quality prescribing and stay within budget."

In order to achieve their aspirations, pharmacists were again identified by some as the key to this process: "More use of pharmacists in helping to improve prescribing."

This is supported by data from interviews with PCG chairmen. When asked to rate 10 potential areas of future primary care investment, prescribing support was the top priority, with nearly 90 per cent rating it as a "high" or "very high" priority. The next priorities were information management and technology hardware and software, and nursing staff.

Some prescribing leads also saw their status as a PCG or potential PCT as an opportunity to "sort out problems" at the primary/secondary care interface and to "get consultants to adhere to the formulary".

DISCUSSION

Data from the initial part of this longitudinal study show that prescribing has been given a high priority within the PCG agenda and has largely been a success story within the first six months of their existence. Most PCGs had set up a prescribing subgroup and were using pharmacists to provide prescribing advice. This is in keeping with data on medicines management from another recently published evaluation of PCGs.⁵ Many prescribing leads themselves identified these and a number of other achievements within the early life of the PCG. This contrasts with other areas of the survey, for example, the questionnaire to information management and technology leads, where little progress had been made.

It is perhaps unsurprising that PCGs had focused on prescribing, given the legacy of prescribing advice within health authorities and the accessibility of PACT data. However, few were using the prescribing toolkit which had been designed to facilitate analysis of PACT data.

There was considerable evidence of the increased use of community pharmacists to provide prescribing support. Clinical governance leads also identified other ways in which they planned to use community pharmacists within the broader arena of medicines management. The agenda for clinical governance is ambitious and the skills of all health care professionals will need to be fully used if significant improvements in the quality of patient care are to be delivered. Clearly, survey methodology does not easily allow validation of responses, but the stated intention to use the skills of community pharmacists in this way would be welcomed by the profession. The development of the roles for pharmacists in primary care may dictate the need to enhance existing skills of to develop new ones. The recently published "Competencies for pharmacists

working in primary care"⁶ provides a valuable framework for the identification of training and development needs.

For the foreseeable future, it would appear that the level of prescribing advice required by PCGs will continue to increase. Some prescribing leads identified this as one of their key tasks for the coming year. This was supported by data from the interviews with PCG chairmen. Of concern is the source of funding to provide the advice. In the early life of the PCGs, the most common source has been the prescribing budget. The near future promises a number of exciting therapeutic advances which, if appropriately used, are set to cause an escalation in prescribing costs but with an ultimate improvement in quality of patient care and outcomes. The successful implementation of the national service frameworks is also likely to increase prescribing costs. There is great potential for a serious conflict between the cost and quality of prescribing. The dilemma arises because an understandable short-term view is taken of costs (the need to remain within budget), whereas improved patient outcomes require a much longer term view. We have not yet entered a culture of investing in prescribing for future health gain.

Another notable finding in the survey

was the way in which GPs within some of the PCGs had developed a philosophy of openness and sharing of prescribing data, a factor identified by a number of prescribing leads as a key achievement. Sharing of data and information among practices could be expected to be difficult for some, given the competitive nature of fundholding. However, it will be essential for this philosophy to extend across many areas of primary care provision. Starting the process with prescribing, where GPs are familiar with discussing their prescribing habits with others, could lead to co-operation and collaboration in other areas, for example, the implementation and monitoring of clinical governance strategy. The sharing of prescribing data should also facilitate the job of the prescribing advisers, who can hold open meetings to share data with all prescribers, rather than having to deal with each practice individually.

In conclusion, the development of prescribing advice and the implementation of clinical governance within PCGs and PCTs provides great opportunities for the pharmacy profession. Pharmaceutical care is entirely consistent with the aim of clinical governance, namely, the responsibility of professionals to improve the quality of patient care and to be accountable for the services they provide.

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