

# The first 18 months of primary care groups: pharmaceutical implications

By *Judith A. Cantrill, MSc, FRPharmS*

**AIM** • To describe how prescribing is being managed within primary care groups and trusts (PCG/Ts) and to identify areas of development over the first 18 months of their existence.

**DESIGN** • Data from self-completion questionnaires and face-to-face interviews

**SUBJECTS AND SETTINGS** • The board members of a stratified, random sample of 57 PCG/Ts in England.

**RESULTS** • All except one of the 57 PCG/Ts had set up prescribing subgroups and 36 (63%) now had community pharmacists as members of these groups. There was evidence of the involvement of a wider group of stakeholders in the prescribing subgroups, including lay members. Pharmacists were providing dedicated prescribing advice to 55 (96%) of the PCG/Ts. In addition, 35 PCG/Ts (61%) were involving community pharmacists or nurses in other specific medicines management

initiatives. Prescribing targets and priorities commonly reflected a combination of national priorities and a desire to develop priorities according to local need. There was a notable increase in the use of e-PACT and the prescribing toolkit in order to help with the monitoring of prescribing within the organisation. Although the organisations were clearly striving to meet the prescribing targets set by the national service frameworks and the National Institute for Clinical Excellence, there was unease about the financial and human resources required to deliver these targets.

**CONCLUSION** • The infrastructure required to support medicines management within primary care is continuing to grow and develop, particularly through the use of community pharmacists, nurses and information technology. In the light of the requirement for all PCG/Ts to have medicines management services in place by 2004, these organisations will need to further develop innovative plans to use their available resources effectively and efficiently.

The 1997 White Paper "The new NHS: modern, dependable" introduced major changes in health service funding and organisation.<sup>1</sup> General practice fundholding was disbanded and replaced by a new network of primary care groups (PCGs). In April 1999, 481 PCGs were established throughout England and these are now evolving or combining to become independent primary care trusts (PCTs), responsible for commissioning health care for their populations and for effectively managing a devolved budget. For the first time within the National Health Service (NHS), prescribing costs in primary care have to be totally managed within an overall budget limit. By April 2001, 164 PCTs were delivering health care to 24.3 million people (48 per cent of the population). From April 2002, PCTs will become the lead NHS organisations in assessing need, planning and securing all health services and improving health. They will receive 75 per cent of total NHS funds to secure provision of services by 2004, when it is expected that all primary care organisations will be trusts. As almost one quarter of a PCT's budget is spent on prescribing, medicines management will be a fundamental part of a PCT's responsibility.

The scale of these changes has already impacted on all the major health care professions, including pharmacy. At the time of the introduction of PCGs, it was argued that a prescribing adviser was an essential post within a PCG in order to ensure that pre-

scribing issues remain high-profile within the organisation and implement effective changes in practice.<sup>2</sup> Indeed, within the first year of the PCGs, prescribing was treated as a priority area for delivering change and this was supported by the employment of prescribing advisers.<sup>3,4</sup>

The aims of this paper are to describe how prescribing is being managed within PCG/Ts and to identify areas of development over the first 18 months of their existence.

## METHODS

Data presented in this paper are derived from the longitudinal Tracker survey being undertaken by the National Primary Care Research and Development Centre. The survey is based on a 15 per cent (n=71; 65 PCGs and 6 PCTs) random sample of all PCG/Ts in England, stratified by NHS region. Data were collected through face-to-face interviews with all PCG chief officers, PCG chairmen and health authority leads. After piloting in four PCGs and two PCTs outside the main sample, self-completion postal questionnaires were sent to all

prescribing leads, clinical governance leads, information management and technology (IM&T) leads, social services representatives, the commissioning lead and a member of the community health council. In early October 2000 respondents were contacted to check willingness to participate, contact details and personnel changes. Questionnaires were sent out in October and November 2000. Full details of this second Tracker survey have been published elsewhere.<sup>5</sup>

The data presented in this paper are largely from the prescribing lead questionnaire, but they also draw on data from some of the other sources where it is relevant to pharmaceutical development. The questionnaire to prescribing leads collected 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 and the use of formularies and guidelines. Respondents were also asked to describe their most significant achievements in the past year in terms of prescribing, the main obstacles or barriers to success and their key tasks for the coming year. 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, and then subjected to thematic analysis.

*Judith Cantrill is professor of medicines (usage, evaluation and policy) at the School of Pharmacy and Pharmaceutical Sciences and National Primary Care Research and Development Centre, University of Manchester, Oxford Road, Manchester M13 9PL*

## RESULTS

The response rate for the questionnaires to the prescribing leads was 80 per cent. This was the second highest rate after clinical governance leads (82 per cent) within the six postal questionnaires included in the survey.

**Prescribing support** In 2000, all except one of the 57 PCG/Ts had a prescribing subgroup (PSG). In addition to the prescribing lead, PCG/T pharmaceutical advisers were members of 84 per cent (69 per cent in 1999<sup>4</sup>) PSGs (Table 1). There was evidence of less involvement of the health authority pharmaceutical (41 per cent *v* 61 per cent in 1999<sup>4</sup>) and medical advisers (9 per cent *v* 12 per cent in 1999<sup>4</sup>). Also of note is the finding that in 2000, 25 per cent of PSGs had a lay member. Other members of the PSGs included practice managers, chief executives, a pharmacy technician, finance managers and clinical governance leads.

In 2000, only two PCG/Ts had no dedicated pharmaceutical adviser, compared with seven in 1999 and a further six that had only ad hoc arrangements at that time. There has been a small increase in the number of PCG/Ts using a combination of dedicated pharmaceutical advice and sessional community pharmacists to help deliver their medicines management agenda (28 per cent *v* 19 per cent in 1999<sup>4</sup>) (Table 2). The single most common source of funding for prescribing support was still by "top slicing" the prescribing budget. Overall, there was increasing use of multiple sources of funding, with 33 per cent now using more than one source. There was also an increase in the use of resources from management budgets (44 per cent *v* 24 per cent in 1999<sup>4</sup>) and a clear decrease in the level of funding provided from health authority budgets (14 per cent *v* 33 per cent in 1999<sup>4</sup>). In the interviews with the PCG/T chairmen, prescribing support was ranked as the highest priority area for primary care investment (86 per cent) closely followed by investment in information technology (84 per cent) and nursing staff (83 per cent).

In addition to providing direct prescribing support for GPs, 61 per cent of PCG/Ts had involved community pharmacists or nurses in other specific prescribing initiatives. The most common areas were implementing aspects of the National Service Framework for Coronary Heart Disease, managing repeat prescribing, reviewing proton pump inhibitor usage and improving prescribing in residential and nursing homes.

**Priorities, targets and incentives** The prescribing leads believed that national policy, eg, NSFs (71 per cent *v* 59 per cent in 1999<sup>4</sup>), and the National Institute for Clinical Excellence (74 per cent *v* 49 per cent in 1999<sup>4</sup>) had now become as influential as the PSG or budgetary constraints in determining prescribing priorities. Compared with the situation in 1999, the influence of the health authority was perceived to have declined when making these types of decisions.

TABLE 1: COMPOSITION OF THE PRESCRIBING SUBGROUP

Member	2000 (n=57)	1999 (n=52)
PCG pharmaceutical adviser	48	33
HA pharmaceutical adviser	23	30
HA medical adviser	5	5
Hospital pharmacist	13	10
Hospital consultant	3	2
Community pharmacist	36	23
*Practice nurse	31	-
*Lay member	14	-

\*Comparable data not collected in 1999

TABLE 2: PROVISION OF PHARMACEUTICAL PRESCRIBING ADVICE

Provider	2000 (n=57)	1999 (n=52)
PCG/T pharmaceutical advisers only	34	25
Sessional community pharmacists only	1	10
Both PCG advisers and community pharmacists	16	10
Neither	2	7
Other	4	0

The top six prescribing targets were specific (eg, increasing aspirin or statin prescribing) or general targets relating to coronary heart disease, generic prescribing, reducing prescribing of proton pump inhibitors, reducing antibiotic prescribing, reviewing repeat prescribing and remaining within budget. These findings have been presented in more detail elsewhere.<sup>6</sup> Although these top targets were the same as in 1999, with the exception of generic prescribing which was already widely used, there was a clear increase in the numbers of PCG/Ts using them. In addition to these top six, there were a further 33 different prescribing targets identified, which covered a wide range of prescribing and therapeutic issues.

Although the influence of the NSF on coronary heart disease was clear, there were notably fewer targets relating to mental health prescribing. These were benzodiazepine prescribing (n=5), antidepressant prescribing (n=3), audit of lithium prescribing (n=2) and general mental health prescribing (n=1).

Overall, 78 per cent of prescribing targets were linked to incentive schemes, 43 per cent to clinical governance priorities and 29 per cent to health improvement programmes. Within the incentive schemes, 38 PCG/Ts (68 per cent) were planning to allow practices to retain prescribing savings, 13 were not and five were unsure. The priorities most commonly linked to clinical governance were in the areas of coronary heart disease, benzodiazepine prescribing, antibiotic prescribing and review of repeat prescribing systems.

**Monitoring prescribing** Almost all PCG/Ts (96 per cent) were using prescribing indicators based on PACT data to monitor prescribing and to identify poorly performing practices (93 per cent). A notable change since 1999 was the marked increase in the use of both e-PACT (83 per cent *v* 43 per

cent in 1999<sup>4</sup>) and the prescribing toolkit (49 per cent *v* 26 per cent in 1999<sup>4</sup>) in order to facilitate this monitoring process. Questionnaires to the IM&T leads showed that prescribing was the area in which information systems best met their needs, with 41 per cent stating that the systems met their needs well or very well. This can be contrasted with the other extreme, where only 6 per cent responding that information systems met their needs in terms of workforce planning.

Sixty-five per cent of PCGs (58 per cent) were sharing identifiable prescribing data with all practices. Importantly, most respondents described their GPs as supportive of this approach with only seven reporting that their GPs were "mixed — some supportive, some resistant" or "mostly resistant".

**Significant achievements** When asked what had been the most significant achievements of the PCG/T in the past year in terms of prescribing, the most common response related to having actively involved practices in prescribing incentive schemes. However, the success criteria used by respondents varied, with one referring to all practices qualifying for payment and another to four out of 14 practices. Other successes were clearly linked to achievement of their prescribing targets and to the development of a PCG/T formulary. Other comments suggested an increased spirit of communication and co-operation within the organisation. This was both within and between practices and between pharmacists and GPs.

**Barriers to success** When asked about the main obstacles or barriers to success in relation to prescribing in the past year, lack of funding for prescribing and the problems with supply of generic drugs and lateness of PACT data were frequently mentioned. Some respondents linked lack of funding to the pressures on prescribing resulting from the implementation of the NSF for coronary heart disease, to NICE guidance and to poor planning for the launch of new and expensive drugs. A number of respondents also referred to the continuing need to "change the culture and the way GPs think and practise" and low GP morale or apathy.

**Key prescribing tasks in 2001** In keeping with the barriers to success perceived by some, others were viewing the implementation, and management of the subsequent resource implications of NSFs and NICE guidance as a key task in the coming year. Others aimed to improve the quality of prescribing yet were still aware of the need to keep within their prescribing budgets. For some the key task was to secure a larger prescribing budget. Other aspirations mentioned included:

- 1 To resolve funding for high cost drugs coming from secondary care
- 1 To cut wasteful prescribing so that all resources can be used effectively
- 1 To have educational meetings for all in 2001

- 1 To improve relationships with practices
- 1 To increase involvement of local community pharmacists
- 1 To tackle poor performance more effectively
- 1 To make the prescribing subgroup work more effectively

## DISCUSSION

The 2000 national Tracker survey shows that the infrastructure to support medicines management continues to grow within primary care groups and trusts. However, in line with the 1999 survey,<sup>4</sup> there is still some evidence that this resource is inadequate to meet all the targets for prescribing in primary care. This second survey does show positive trends, with increased human resource provision through more dedicated pharmaceutical support and increased use of community pharmacists and nurses. This is clearly an area that is still being given high priority for investment, notably by the chairmen of these organisations. This implies a recognition that more pharmaceutical resource is required to support the ever increasing medicines management agenda.

This survey also provides some evidence of the involvement of a wider range of stakeholders within the prescribing subgroups. However, the survey methodology does not allow us to explore either the impetus for these developments or whether this represents true stakeholder commitment and involvement. For example, there is no evidence to date of the nature and extent of involvement of lay members within the business and decision-making of the prescribing subgroups or other groups within the PCG/Ts.

There are also signs that these organisations are beginning to address the need to modernise the NHS by extending the range of services available and supporting quality improvement, particularly around the NSF for coronary heart disease. There is clear evidence within the prescribing targets and priorities that the PCG/Ts are striving to implement the NSF. However, coronary heart disease was also a high priority in last year's survey. It is not known whether this finding was in anticipation of the NSF or in response to an already identified local health need. Nevertheless, this issue of coronary heart disease targets was recurrent throughout the current survey: it impacted not only on prescribing targets but also on guideline production and use of other health care professionals, and impinged upon their perceived barriers to success and key tasks for the future.

Although the NSF for coronary heart disease and NICE guidance had been given a high priority, their perceived ensuing negative effect on budgetary control was evident. The NSF for Mental Health, which was less directional than that for CHD in terms of how medicines should be used, had perhaps understandably had much less impact on prescribing policies. The NSF for Older People was published after this survey took place and its content was not easy to

predict. The next survey will give an indication of whether and how the PCG/Ts have organised services to meet the targets within this NSF, notably those relating to medication review. The next NSF to be published will be that for diabetes and it is widely expected that, like the NSF for coronary heart disease, it will have quite specific recommendations on how a wide range of medicines should be prescribed in this group of patients. Trial evidence strongly suggests that in a number of areas of care these patients are untreated and many require additional therapies.<sup>7</sup> This strongly implies that implementation of the NSF for Diabetes will put further pressures on both service delivery and prescribing budgets. However, the Government has recently announced that the implementation of the diabetes NSF will be delayed until 2003.

Evidence of the impact of centrally produced guidance was also suggested by the high priority given to the prescribing of proton pump inhibitors. However, although NICE guidance on PPI prescribing was published during 2000, PPI prescribing also featured as a high priority in the first survey that predated this guidance. This may suggest that decisions to focus on this group of drugs had been driven by the desire to reduce prescribing costs in this therapeutic area.

Another Government target which was also being addressed was evident through strategies aimed at reducing antibiotic prescribing. Although the most frequently identified prescribing targets appear to reflect centrally led targets, the number and diversity of areas involved also suggests that the PCG/Ts also have some freedom to develop priorities according to local need.

Mechanisms to monitor and review prescribing appear to be strengthening with over 80 per cent now using e-PACT and almost half using the prescribing toolkit. Many PCG/Ts were sharing identifiable prescribing data with all practices and few reported resistance to this practice. This culture of increased sharing and co-operation both within and between practices is a noteworthy development since the inception of PCGs. In response to the open question about achievements in the past year, this spirit of co-operation was frequently referred to in the first survey but much less so in this second one. This may suggest that openness and sharing is now becoming accepted as normal rather notable behaviour.

Although it is not possible to comment on trends, as there was no comparable question within the first round of this survey, almost two thirds of PCG/Ts were using community pharmacists and nurses in prescribing initiatives. In relation to community pharmacists, the question specifically asked respondents to this section not to include community pharmacists who were providing sessional prescribing support within the practices. The services relating to community pharmacy were being provided in a number of settings: the community pharmacy, residential homes, nursing homes and the patient's own home.

## CONCLUSION

The infrastructure required to support medicines management within primary care is continuing to grow and develop, particularly through the use of community pharmacists, nurses and information technology. In the light of the requirement for all PCG/Ts to have medicines management services in place by 2004, these organisations will need to further develop innovative plans to use their available resources effectively and efficiently. The further extension of nurse prescribing and the introduction of pharmacist prescribing will provide the opportunity to deliver more holistic care without continual reference back to the GP. The recent survey of over 20,000 GPs, conducted on behalf of the British Medical Association, shows that 75 per cent agree or strongly agree with the proposals to extend nurses' prescribing responsibilities and 64 per cent have the same view on the introduction of prescribing by pharmacists and other health care professionals.<sup>8</sup> There appears to be growing recognition among a number of professional groups that sharing responsibilities for medicines usage is the way forward to deliver safe and efficient patient care.

*This paper was accepted for publication on 6 March 2002.*

## REFERENCES

1. Department of Health. The new NHS: modern, dependable. London: Stationery Office; 1997.
2. Rose S, Ashworth M, Colwill S, Armstrong D, Balazs J. Prescribing all set to change in the new primary care groups. *Pharm J* 1999;262:301-2.
3. Cantrill JA, Leese B. An exploration of the potential impact of primary care groups on pharmaceutical practice. *Pharm J* 2001;266:857-9.
4. Wilkin D, Gillam S, Leese B. The national tracker survey of primary care groups and trusts: progress and challenges 1999/2000. National Primary Care Research and Development Centre and King's Fund; 2000.
5. Wilkin D, Gillam S, Coleman A. The national tracker survey of primary care groups and trusts 2000/2001: Modernising the NHS?. National Primary Care Research and Development Centre and King's Fund; 2001.
6. Cantrill JA, Leese B. Prescribing incentives and guidelines. *Primary Care Pharmacy* 2001;2:1-2.
7. American Diabetes Association. Implications of the United Kingdom prospective diabetes study. *Diabetes Care* 1998;21:2180-4.
8. National survey of GP opinion. Available at URL: <http://www.bma.org.uk/public/webdocs.nsf/webdocswv/NationalSurvey> (accessed 19 March 2002).