Influencing Prescribing Cost and Quality in Primary Care

A SUGGESTED COMMUNICATION PLAN FOR PRESCRIBING ADVISERS | MAY 2007

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This report can be found on the National Audit Office web site at www.nao.org.uk

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CONTENTS

SUMMARY 4

ONE
Introduction 6

TWO
Effective communication process 8

THREE
Defining your territory 9

FOUR
Targeting your effort 12

Assessing the financial impact of activities 13

Measuring the impact on patients 15

Finalising medicine priorities 15

Targeting practices 16

FIVE
Segmenting your practices 17

SIX
Visiting the Clinicians 19

Build a relationship 19

The relationship process 20

Getting your plans adopted 22

Getting the agreement 23

Supporting activities 24

Follow up and monitoring 25

SEVEN
Communication materials 26

Communication pieces and suggested content 27

Benchmark data, ePACT and the PSU 27

Information from the National Prescribing Centre 28

Sample communication piece 29

EIGHT
Managing your information 33

Collecting and storing information 33

The Freedom of Information Act 34

NINE
Review and revitalisation of your plans 35

TEN
Conclusion 36

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SUMMARY

The purpose of this document is to provide prescribing advisers in Primary Care Trusts (PCTs) with some straightforward suggestions on how to drive both clinical and cost-effective prescribing initiatives through more effective planning of communication and targeting of clinicians. We have drawn on information presented in the National Audit Office Report *Prescribing Costs in Primary Care*, and seek to provide practical advice to support some of the recommendations. Whilst we would never equate the role of a prescribing adviser with that of a pharmaceutical sales representative, we have highlighted some of their more effective approaches to planning and communicating with clinicians and how they may be adapted.

We provide suggestion on the following aspects of effective communication planning:

Defining your territory

Within many PCTs there is more than one prescribing adviser. This section outlines the process by which you should select who within the team is responsible for each practice. Historical relationships are critical to this division of labour. However, it is important to ensure that both workload (numbers of practices and GPs) and potential degree of change (number of patients impacted by change) are evenly balanced between each of the prescribing advisers. This balance is crucial if prescribing advisers are to achieve the maximum impact.

Targeting effort

The effort and expenditure behind prescribing initiatives are both 'investments' from which a 'return' (cost and clinically effective prescribing) is required. Once we have defined this 'return on investment', we can outline methods to optimise it. Return is defined in terms of patient benefit and potential cost savings, although we do not seek to make any value judgments about the relationship of the two. Investment is defined in terms of all costs associated with prescribing initiatives, including the treatments, the costs incurred during change, and the time of the prescribing adviser. We seek then to target our effort in two stages. The first involves selecting the appropriate initiative, which should take account of both patient impact and financial implications. The second involves targeting effort and expenditure at those practices which will provide the greatest return. This is achieved by considering not only the overall potential impact of the change, but also its associated costs and any potential barriers.

Segmenting practices

Practices can be divided into groups based on different levels of potential impact, as well as their ability and willingness to change. For each group, an action plan can be created which is both cost-effective and tailored to individual circumstances.

Visiting the Clinicians

The most effective – but also most expensive – method of communicating with clinicians is to visit them. It is therefore crucial to make the most of every visit. We suggest a process to help you achieve this, from building better relationships to monitoring performance and following up with the clinician. We also use a simple framework to explain how clinicians might adopt your agenda, a process of raising awareness and interest, making the decision to change and finally taking action. We outline a number of supporting activities which can be used to help practices achieve their objectives.

Communication materials

Visits have far more impact if communication materials reinforce the prescribing strategy. We outline the different types of communication materials such as letters and communication pieces for meetings. We also provide an example of a good communication piece, and analyse it in terms of format, flow and content.

Managing Information

The foundation for rational decision-making is information. We outline the different types of information and what should be stored, and suggest that the best solution for data storage and management is probably the simplest. Additionally, we raise implications of the Freedom of Information Act (2000) for storing information on individual practices.

Reviewing and revitalising plans

Planning regular reviews of the different aspects of communication is critical. We provide a simple review schedule and outline activities such as ensuring information is up to date, reviewing performance and managing budgets. It is important to plan not only what types of activity are performed, but also the frequency and who should be involved.

The contents of this document have been developed in conjunction with the National Prescribing Centre, the Department of Medicines Management at Keele University, and a selection of prescribing advisers and medicines management experts across England.

ONE

Introduction

This document is intended for Primary Care Trusts, and specifically for prescribing advisers. It does not encompass all the wide-ranging and demanding activities that make up the job of a prescribing adviser (ensuring safety, concordance, etc.). Rather its purpose is to suggest ways to increase the impact of your communication with GPs in driving both clinical and cost-effective prescribing initiatives, benefiting both patients and the local health economy. This can be applied to medicines which are already on the market, or it can follow your horizon-scanning intelligence, when you talk to clinicians about new products or product changes before they arrive. It does not try to impose or stipulate a method, but instead to make suggestions which may be useful. Some of the material may be familiar to many of you, but we have sought to be as inclusive as possible, both to reinforce what you may already be doing and to benefit those newer to the role of prescribing adviser.

Two key questions, for consideration, when trying to understand effective methods of driving change with clinicians are:

1. If the model of the sales representative visiting GPs does not drive the sales of a product, why do pharmaceutical companies persist in making significant investments in the sales force?
2. Why do clinicians choose one specific product over another when there is limited evidence of the clinical difference between them?

There is an old adage that 'people don't buy things, they buy other 'people', and this answers both our questions. Having a good relationship with a GP provides the environment for effective communication of the messages pertaining to the product. The GP does not necessarily need to prescribe a specific product and has many alternatives, such as competitor products, a different therapeutic approach, or no treatment at all. But it is the relationship with the adviser that allows the necessary dialogue, ensuring effective communication of the key messages and the rational use of medicines. The National Audit Office (NAO) survey of prescribing advisers asked: 'What are the best ways of influencing GPs' prescribing habits?' The most popular response was 'greater contact time with GPs', followed by 'financial incentives'.

Greater contact time with GPs is traditionally what all pharmaceutical companies strive for to drive the sales of their products. However, prescribing advisers are more effective at influencing GPs' behaviour: the GP survey presented in the NAO report shows that two thirds of the GPs surveyed said that prescribing advisers have more influence on their prescribing behaviour than pharmaceutical companies. Forty three per cent indicated that prescribing advisers have much more influence than the industry. Both groups report having a positive working relationship.

As a pharmaceutical adviser seeking to drive change with clinicians, you face a number of challenges which are, at first glance, similar to those faced by the pharmaceutical sales representative. First amongst these is that you are trying to influence them to make, or change, specific prescribing habits whilst having limited ability to 'enforce' or 'require' any change. Secondly, the resources you have to hand are limited. Like the pharmaceutical sales representative, you can only achieve your objectives through providing clear, strong and effective communication with well articulated reasons and recognisable benefits.

You will be more effective if you recognise, empathise with and help manage the difficulties that prescribers have in switching or altering current patterns of behaviour. We will be looking at some of the appropriate techniques used by pharmaceutical companies for maximising their impact throughout their customer base.

As pharmaceutical sales representatives only have between two and three face-to-face meetings with GPs per day, and each of these visits is of a very limited duration, they have to be as effective as possible. They do this by concentrating their effort on a limited number of products, with clear incisive communication targeted to have optimum impact. They are supported by marketing departments, sales managers, in-field trainers and so on, whose function is to make them more effective and improve their impact. They also have access to the latest technology and infrastructure support. Additionally, they recognise that there is a process to selling, and take clinicians through the key product adoption steps.

As prescribing advisers within the environment of your local PCT, you have a much broader role than that of a pharmaceutical sales representative. To make an impact you have to advise on many diverse medicines and relevant prescribing information. Also, prescribing visits are only a small part of the effective management of prescribing; it requires engagement from key opinion leaders, joined-up working between primary and secondary care prescribers, and provision of networking opportunities for prescribers to learn from each other.

However, you have a number of advantages over the slick, focused, single message of the pharmaceutical sales representative. Principally you have greater access to GPs, both through your relationship with the PCT and ultimately through the Quality and Outcomes Framework (QOF) of which 'Medicines Management Target 10' states '*The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change*'. Additionally, 'Medicines Management Target 6' states '*The practice meets with the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing*'. This presents opportunities for both initial and follow-up visits. It works well if the practices agree to audits that fit with the PCT's agenda. The NAO reports that 92 per cent of practices claim the points for reaching both of these targets, although experience suggests that occasionally they agree to actions which are not aligned to the agenda of the PCT.

As well as being skilled at understanding many detailed issues around the treatment of patients with a broad range of medicines, you are armed with more accurate data on prescribing. Additionally, you are acting on behalf of the health providers and are responsible for highlighting the clinical responsibility of GPs. Ultimately, you both have the same objective and greater credibility in generating the best outcomes for patients. In many PCTs, you are able to develop incentive schemes around the prescribing budget, which can help support clinical and cost-effective prescribing recommendations. Although you carry the PCT medicines management agenda, other issues may arise in discussion with the clinicians which may provide easier gains to both the practice and the local health economy. A key skill you have is to balance the needs of the PCT against the needs of the practice, whilst building or maintaining a positive relationship.

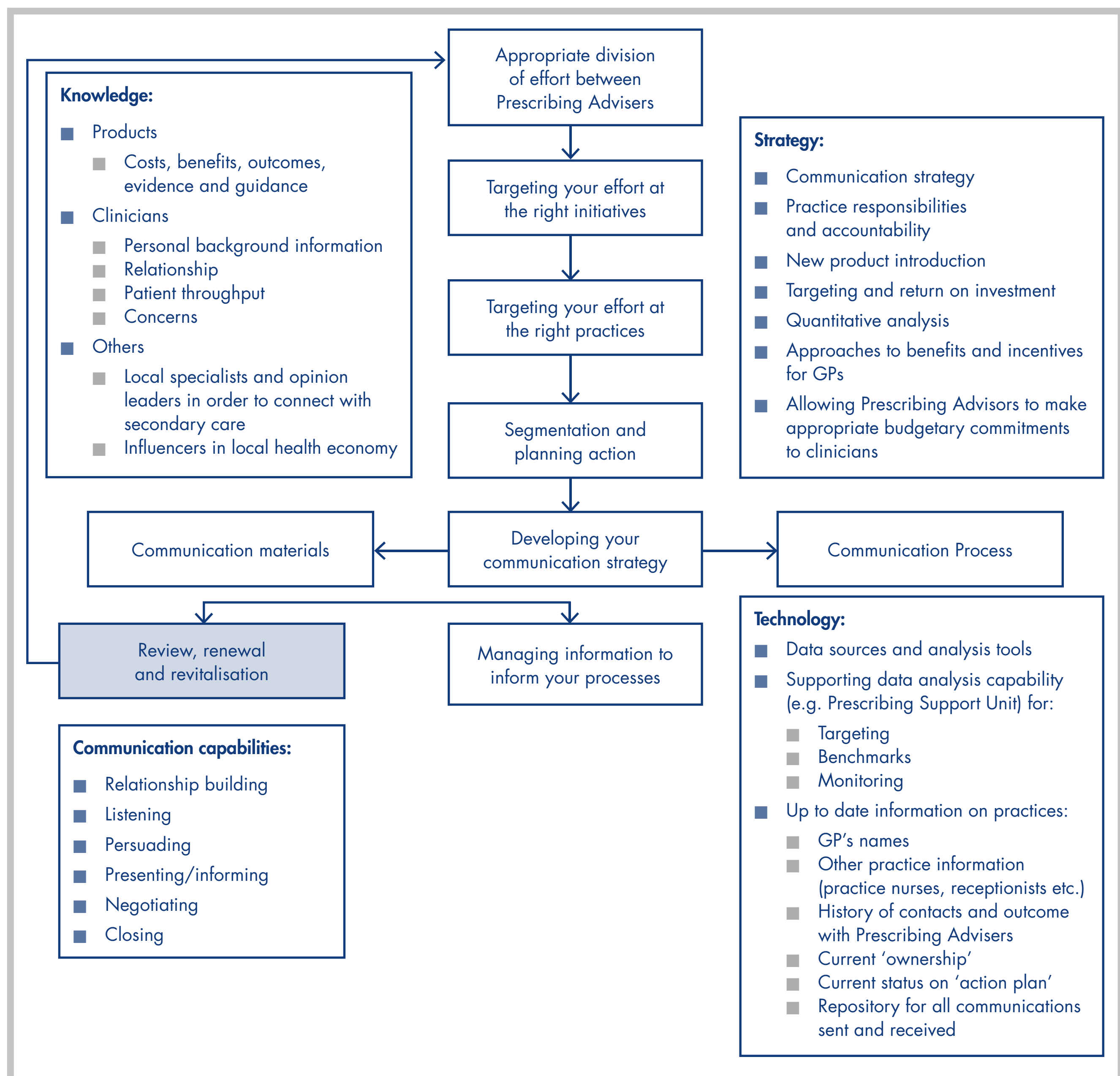
One of the aims of Practice-Based Commissioning is to encourage GPs to get greater value for money from their overall budgets. This should provide a lever for improving value for money in medicines expenditure. However, as shown in the NAO report, its potential has yet to be tested. Thirty seven per cent of GPs surveyed did not know what impact Practice Based Commissioning would have on their medicines bill, and twenty per cent said that it would not encourage their practice to make any savings. Thirty six per cent said that Practice Based Commissioning will encourage small savings, and eight per cent that it will encourage significant savings. Accordingly, GPs will need continued support from PCTs in managing their prescribing, where help is needed to manage their budgets, and also where Practice-Based Commissioning has yet to significantly influence behaviour.

Use the advice provided in the following pages, or selected parts of it, to review or remodel your approach to clinicians. Re-examine your processes to focus on key cost-effective prescribing priorities to benefit clinicians, patients and the local health economy through the appropriate redistribution of resource spend. Although we suggest a number of straightforward approaches to ensure that your effort is well placed and the process and materials you use are optimised, effective communication ultimately relies on your individual ability to listen to, empathise with and talk to clinicians.

TWO

Effective communication process

In this document we focus on the effective interaction of prescribing advisers with the community of clinicians, from division of labour to managing and communicating your messages with prescribers. The following chart illustrates the key aspects of generating an effective communication plan for clinicians.

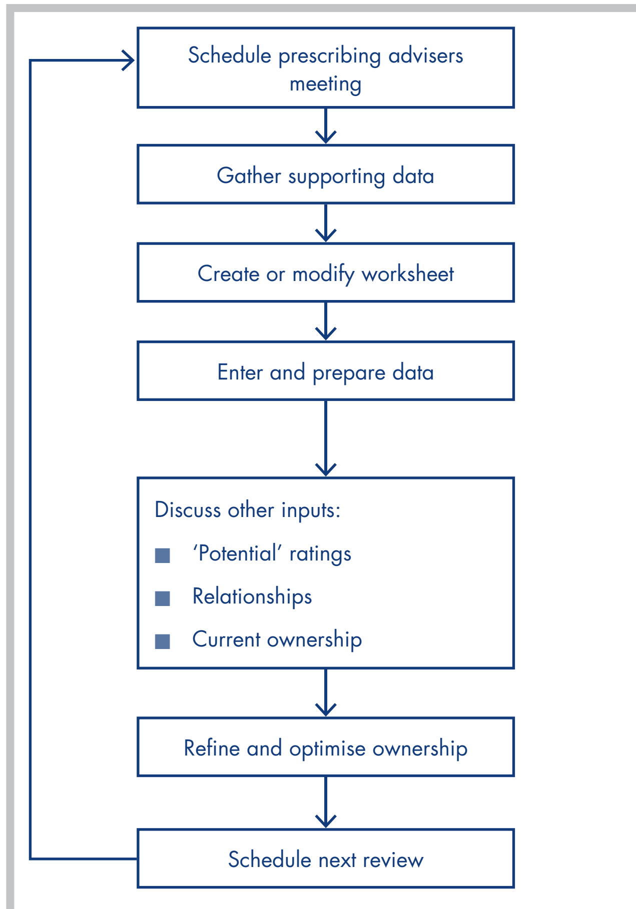


THREE

Defining your territory

Assuming that there is more than one prescribing adviser within your PCT, it is critical to agree the GP practices that you will be responsible for assisting.

The objective of defining territories is to provide equal levels of workload for each prescribing adviser, without disrupting working relationships with the clinicians. With disproportionate effort between advisers, some of the highest priority activities will fail to be addressed. This is a critical process that pharmaceutical companies go through to ensure that the foundation of the structure enables optimal distribution of effort.



The process of reviewing who should 'own' which practices should include the following steps:

1. Compile a list of all practices in your PCT including the number of GPs for each.
2. Identify where practices may be part of a practice-based commissioning group (PBCG), as the group should be treated as one entity. Depending upon the size of the group, you may need more than one adviser to cover them effectively, but they should not be split across many advisers unnecessarily.
3. Discuss each practice and give them an approximate score for the potential improvement that could be made:
   - This could be achieved by looking at their total spend per patient or ASTRO-PU.[1] Alternatively it could be achieved by looking at a specific medicine per patient, ASTRO-PU or STAR-PU.
   - It is not meant to be perfect, merely a rough guide to those that may need more or less assistance. For instance, depending on the level of potential improvement for each practice, you may wish to assign a number between 1 and 6.
4. Add a column for each of you and your colleagues and record for each of the practices you have:
   - Good relationships
   - Weak or limited relationships
   - No relationships
5. Add a final column that contains who is currently responsible for each practice.

1 A good explanation of these measures is provided by the NHS Information Centre at: www.ic.nhs.uk/our-services/prescribing-support/measures.

The spreadsheet may look something like this simplified example:

Practice	PBCG	GPs	Potential	Prescribing Advisors A	B	C	Select Ownership
Ash street surgery	0	6	4	Weak	–	–	A
Briar patch surgery	0	4	3	–	Good	–	B
Chestnut Grove	0	1	1	–	–	Good	B
Hawthorn Group	1	5	3	Good	–	–	C
Rowan Lane surgery	0	3	3	–	–	Weak	B
Walnut Group	1	5	4	Good	–	–	A
Willow Bank surgery	0	5	3	–	Weak	–	A
Yew tree surgery	0	4	1	–	–	–	C

Using this sheet, it is important to consider the balance between each of the prescribing advisers, (A, B and C) shown in the example above. In this example, the amount of working time available for each prescribing adviser is expected to be similar; this will not always be the case. You should balance the planned effort with the available time that each prescribing adviser has.

The number of GPs, their ‘potential’, and the number and types of relationship, can be extracted from the above table, and are represented below:

Advisor	GPs	Potential	Ownership Good	Weak	None
A	16	11	1	1	1
B	8	7	1	0	2
C	9	4	0	0	2

As you can see from the above example, the number of GPs and the amount of potential available to each prescribing adviser is not well balanced. Additionally, the prescribing advisers are failing to capitalise on the good relationships they have, and are not avoiding the weaker relationships.

Once you have agreed the underlying data and understood the current balance of your potential, workload and relationships, it is critical to discuss it and make changes as to who ‘owns’ individual practices.

The objective of the review should be to:

1. Balance the number of:
   - Practices
   - Total number of clinicians (workload)
   - Total potential for savings (potential)
   - Good/weak/no relationships
2. Reinforce and strengthen good relationships; building new relationships is much harder than maintaining old ones
3. Understand where you have a weaker relationship and the underlying reasons for this. With these you should either alter your approach or use another prescribing adviser who may be able to develop a better relationship with the practice
4. For those where you all have similar or no relationships, select on the basis of:
   - Geography – keep the territories similar
   - Providing a balance (both workload and potential)
   - Who may best fit the style of the practice

If you complete this process using some of the above concepts or rules, you will have created individual ‘territories’ which have appropriate amounts of work and potential for change. This means the level of activity and priority for each prescribing adviser will be consistent and that the environment is optimised for you to achieve the greatest possible impact.

If we take our simple example, we can improve the balance thus:

Practice	PBCG	GPs	Potential	Prescribing Advisors A	B	C	Select Ownership
Ash street surgery	0	6	4	Weak	–	–	C
Briar patch surgery	0	4	3	–	Good	–	B
Chestnut Grove	0	1	1	–	–	Good	C
Hawthorn Group	1	5	3	Good	–	–	A
Rowan Lane surgery	0	3	3	–	–	Weak	B
Walnut Group	1	5	4	Good	–	–	A
Willow Bank surgery	0	5	3	–	Weak	–	C
Yew tree surgery	0	4	1	–	–	–	B

Advisor	GPs	Potential	Ownership Good	Weak	None
A	10	7	2	0	0
B	11	7	1	0	2
C	12	8	1	0	2

The improved balance in terms of number of GPs and potential for each prescribing adviser is clear. No-one goes to a practice where they currently have a weak or limited relationship and everyone capitalises on their good relationships. Additionally, the recognition of the one PBCG should provide a firm foundation for greater impact in our small imaginary PCT.

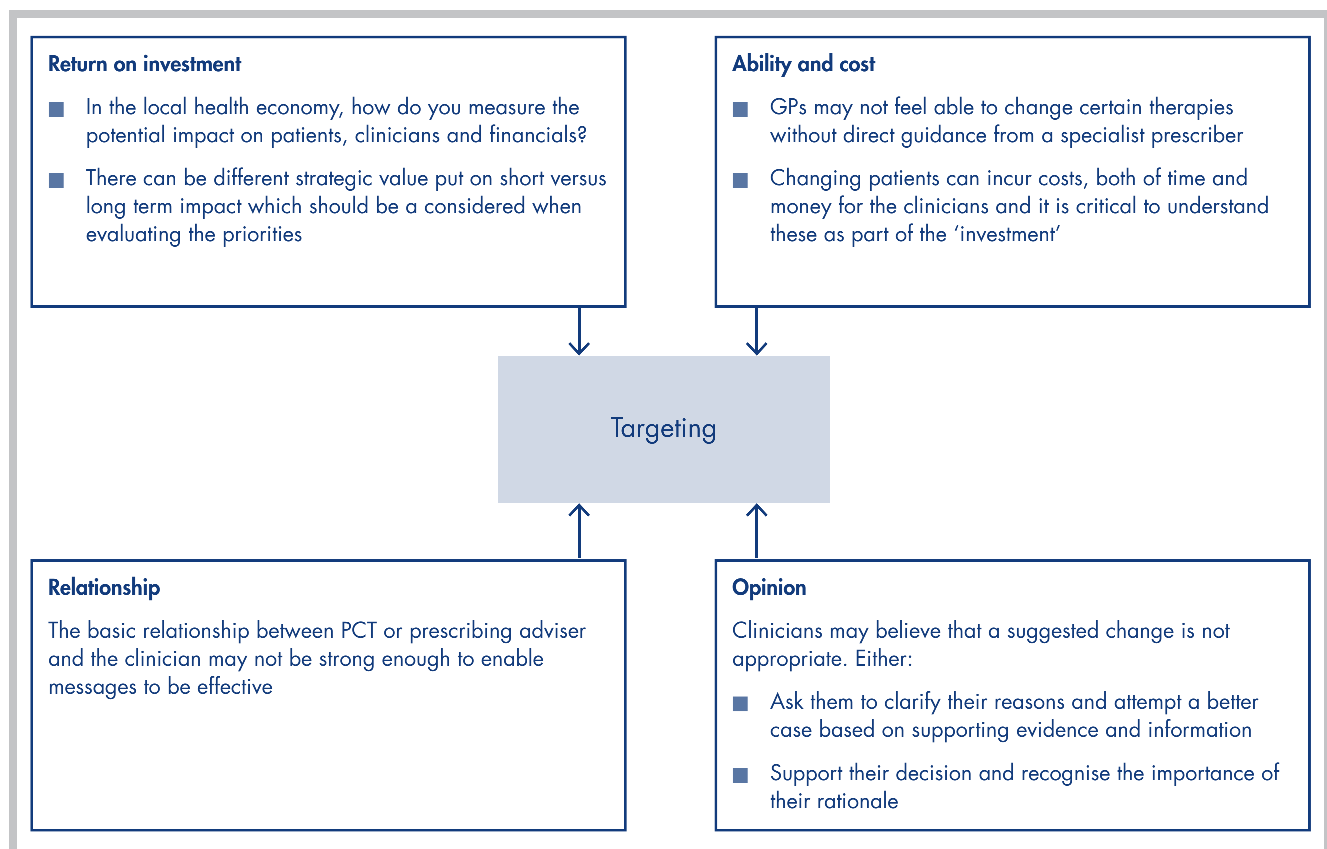
FOUR

Targeting your effort

Commercial sales organisations focus on optimising return on investment. Simply put, they ensure that limited resources are put to best use. For an expensive resource like sales representatives, targeting is integral to the process of optimisation. Targeting relies on understanding the market place and understanding where each sales representative can have the most impact. The pharmaceutical industry commonly considers that for a mass market product, 50 per cent of GPs are responsible for around eighty per cent of product sales. The critical activity is to find the 'top 50 per cent'. Likewise, as a prescribing adviser you cannot see all your practices weekly about every prescribing improvement opportunity.

It is equally critical for you to prioritise the activities and practices you work with, and the amount of effort you put behind them.

As the basis of prioritising your activity, you have data which the pharmaceutical industry does not, namely the ePACT data. Targeting isn't just about the impact you could achieve in absolute terms, it is also about understanding whether there are barriers within each practice such as a lack of willingness, or ability, to change and how these factors may reduce the potential return or increase the amount of effort required.



Additionally, it is critical to ensure that the key messages you are trying to communicate with the GPs are effective. It is important not to use up valuable time with information which will only cloud the argument as GPs have limited time to process all the material they receive related to prescribing. From the NAO report, seventy five per cent of the GPs surveyed estimated that they read less than half of the prescribing information they received over the past year; and forty per cent said they read less than a quarter. Most GPs in the focus groups, conducted by RAND Europe as part of the NAO study, felt their practice was only able to focus on two or three issues in prescribing at any one time.

There are two aspects to the targeting process. Firstly, it is essential to determine which target medicines will provide the best return on investment. Secondly, once a group decision has been made for the PCT, it is important for you to prioritise which practices to take this particular cost- and quality-effective message to. We will seek to define return on investment, and suggest how to prioritise potential initiatives, and which practices to target in the following sections.

Defining 'return on investment'

When seeking to drive a cost-effective prescribing change, or to prepare the market for the entry of a new product, it is important to understand what types of benefits you are seeking from the change.

Factors which define the return could be:

- Lower cost of treatment for similar patient outcome;
- Stopping the use of unnecessary medicines where patients do not or have not responded, or have completed the recommended period of treatment;
- Switching appropriate patients to lower cost medicine with similar outcomes;
- Better patient outcomes or convenience;
- Increasing prescribing of certain medicines or therapeutic classes;
- Switching to more effective treatments; and
- Switching to products which encourage compliance or are more convenient.

We are not seeking to provide absolute value judgements about certain treatments, but rather to help you prioritise your activities.

Assessing the financial impact of activities

Financial assessment of any initiative is composed of two components: the return and the investment. As we have already outlined, a return could be either a financial saving or a direct patient benefit. We will initially concentrate on the financial return.

We would suggest brining your medicines management team together in a meeting to draw up a short list of potential initiatives specific to your PCT. For each potential initiative you have identified, you should seek to generate a table containing the following information:

- List of practices;
- Practice spend on the medicine associated with this potential initiative; and
- ASTRO-PUs or some other normalising factor for this practice.

From this you can calculate spend per ASTRO-PU per practice. This information will also be available from the PSU web site (outlined in section 9). This could be plotted on a chart to understand not only what the potential for savings might be, but within how many practices there is potential for saving. Smaller savings made across many practices may be less attractive than larger savings in a smaller number of practices, purely because of the amount of time you will need to invest to make a change.

From the chart, and perhaps with input from other appropriate PCT benchmarks (via the PSU web site), you can choose where to set your target. This target will define the number of potential practices on which to focus your activities. Using your target you can then calculate:

- Number of practices to be approached;
- Level of reduction in spend per 1,000 ASTRO-PUs (or another appropriate normalising factor) including any substituted therapy used; and
- Total cost saving across all target practices.

This total cost saving across all target practices represents the total opportunity. However, you will need to allow for issues which may prevent you from gaining all of this such as:

- Percentage of practices willing and able to make change;
- Percentage of target to be achieved on average.

If you multiply the total cost saving across all target practices by each of the above percentages you will have calculated your potential **return**.

If this is for a new treatment, or for a treatment which shows better patient outcome but for a higher cost, this return will be a cost, not a **return**, and should be represented as such.

On the cost side you need to consider:

- Working days per practice you estimate you will need to make a change;
- The cost of a day of your time;
- Rough estimate of the cost of the change per practice;
- Number of target practices.

Additionally, you need to consider the time period over which you measure the current and target spend. One-off initiatives may show a return over at least one year depending upon your choice of target. The length of potential saving and the value of short and long term change needs to be taken into account in your calculation of potential return.

Multiplying the working days per practice by the average day cost of a prescribing adviser gives you the cost per practice. Adding to that the cost of the change per practice and multiplying this by the number of target practices gives you a sense of the overall investment in making the change.

This allows you to understand the financial aspects of each potential activity. To repeat the above calculation:

Return =

((Current Spend per 1,000 ASTRO-PU in each target practice	–
Target spend per 1,000 ASTRO-PU in each target practice)	x
Average ASTRO-PUs per practice)	/
1,000	x
Number of target practices	x
Percentage of target practices willing and able to change	x
Percentage of target achieved on average	

Investment =

(Working days per practice required for change	x
Cost of one day of your time	+
Cost of change per practice)	x
Number of target practices	

Using a numeric example to illustrate the calculation gives us:

Return =

((Current Spend per 1000 ASTRO-PU in each target practice	((£1,000	–
Target spend per 1000 ASTRO-PU in each target practice)	£500)	x
Average ASTRO-PUs per practice)	30,000)	/
1000	1,000	x
Number of target practices	12	x
Percentage of target practices willing and able to change	75%	x
Percentage of target achieved on average	80%	

Return = £108,000

Investment =

(Working days per practice required for change	(10	x
Cost of one day of your time	200	+
Cost of change per practice)	£1,000)	x
Number of target practices	12	=

Investment = £36,000

This example activity generates a good return on investment, but what is important is whether this is more, or less, than alternative initiatives. We are not seeking to make an absolute measure of the return on investment of any change; rather we are seeking to prioritise activities. As such it is not necessary to be totally accurate, but it is more important for you to be consistent when comparing each initiative. Also, we advise you to consider the cost of your time, in order to make a comparison with other potential investments, such as using a third party. However, it is obvious that as a fixed cost, you should ensure that your time is filled with appropriate activities, even if some of them show negative returns.

Measuring the impact on patients

Putting a value on patient outcomes is extremely difficult, and requires significant health-economic modelling. As such, we will take an extremely simplified view, defining both major and minor, positive and negative 'impacts' on individual patients. This level of impact, combined with total number of patients for each practice that are treated using the current approach and how many would potentially benefit from a change, can form the basis of selecting initiatives.

Using group judgment and available evidence, you should estimate the values for the impact on patients. This is a very broad measure, and is difficult to quantify outside specific examples. Types of impact may include:

- Clinical effectiveness;
- Convenience;
- Side-effect profile;
- Compliance or adherence to therapy;
- Effect on carers or others; and
- Emotional.

At the end of the activity targeting process, you should have generated a series of potential initiatives and evaluated them on several key dimensions. The example below illustrates some potential initiatives, the figures and judgment associated with them, and the initial prioritisation:

Presenting the information in this way allows rational choices to be made about priorities within your local area. At this point it is necessary for your team to make value judgments between cost effectiveness and improving patient outcomes.

Finalising medicine priorities

At this point you should take into account any number of other potential factors before making a final selection. These factors may include, but are by no means limited to:

- Long-term versus short-term priorities for the PCT;
- Difficulties associated with changing secondary care practices;
- Any potential risks;
- Lack of supporting clinical evidence for a change;
- Other costs associated with changes; and
- Upcoming product price changes or new market entries, including generic or OTC alternatives.

Using these other factors in conjunction with the above table will allow the team to prioritise specific initiatives. Although prioritisation is a time-consuming activity, it is critical to ensure consistent, rational decision making about where valuable resources are best placed within your local health economy.

Example initiative	Return	Financial Investment	Total	Number of patients	Impact	Priority
Review therapy	£150,000	£25,000	£125,000	10,000	None	1
Change presentation	£40,000	£15,000	£25,000	500	Minor – Negative	5
New therapy	(£100,000)	£10,000	(£110,000)	5,000	Major – Positive	2
Use new formulation	(£30,000)	£25,000	(£55,000)	1,000	Minor – Positve	6
Drive to OTC	£80,000	£5,000	£75,000	6,000	Major – Negative	7
Change dosing	£0	£5,000	(£5,000)	5,000	Minor – Positve	3
Add-on	£0	£10,000	(£10,000)	100	Minor – Positve	4

Targeting practices

Once an initiative has been selected, it is important to mirror the reason for the selection of that initiative when prioritising practices. For instance, if the selection was made on the basis of the number of patients benefiting, rather than potential cost saving, it is important to calculate the number of such patients on a practice-by-practice basis. If, however, an initiative was chosen on the basis of cost-effectiveness, it is crucial to prioritise by savings per practice.

For a cost-effective saving you could use the following algorithm:

- Calculate the total spend per 1,000 ASTRO-PUs for each practice;
- Subtract the target spend per 1,000 ASTRO-PUs from each value;
- Multiply by the number of ASTRO-PUs for each practice.

The result will be the potential size of saving.

This should not be the end of the targeting, and you may wish to take into account one or more of the following, which may reduce your potential impact. You can do so either by moderating the score or by having separate scores.

- Willingness and ability to engage;
- Early or slow adopters of new medicines;
- Influence by pharmaceutical industry;
- Influence on, or influenced by other practices;
- Practice-based commissioning groups;
- Available resources to make the changes;
- Status of relationship between prescribing adviser and practice;
- Potential level of effort required to instigate change across all prescribers in a practice.

When you have a clear picture of practices' ability to make savings and their attitudes to change, you can define the practice segments and deliver action plans against each segment. This segmentation and planning is outlined in the next section.

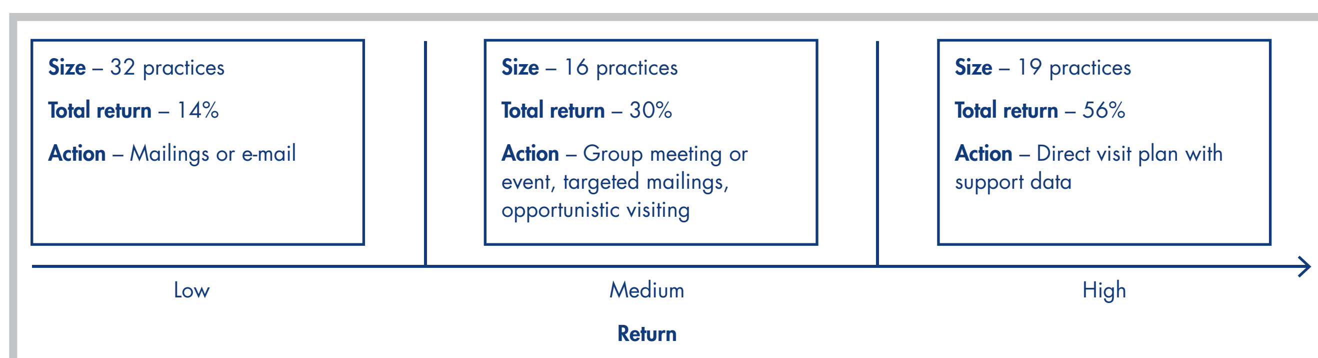
FIVE

Segmenting your practices

When you have prioritised both the initiatives you are going to work on and the practices you will work with, it is important to consider what is appropriate not just for the practices with the highest potential return on investment, but for all of them. There are several reasons for this:

1. You should consider all the options available to you for communicating the messages you wish to deliver. Based on the relative priority and characteristics of each group of practices, you can fit your actions to each segment such that it delivers the greatest savings for the least cost.
2. Additionally, you should consider the different ways that clinicians react to influences. For example, the 2003 paper by Prosser and Whalley[2] cited in the NAO report showed that high and low prescribers of new medicines were influenced by radically different sources of information.
3. Perhaps most importantly, and requiring immediate attention is whether inconsistent prescribing decisions are significantly impacting patients within your PCT. This needs to be addressed with all practices via the most appropriate means. No patient should be disadvantaged through focussing on larger practices only.

When considering individual practices, you may determine that they differ from each other only in the return on investment from each other, while their attitudes to change remain roughly similar. In this case you may have a simple segmentation that looks like this:



2 Prosser H and Walley T, New medicine uptake: qualitative comparison of high and low prescribing GPs' attitudes and approach, Family Practice 2003, 20: 583-591.

The division into the groups (high, medium and low) can be based on a number of different factors, such as:

- Desire to have a certain number of High, Medium and Low practices
- Cut off values such as 50 per cent above target, above target and below target
- Natural cluster of practices

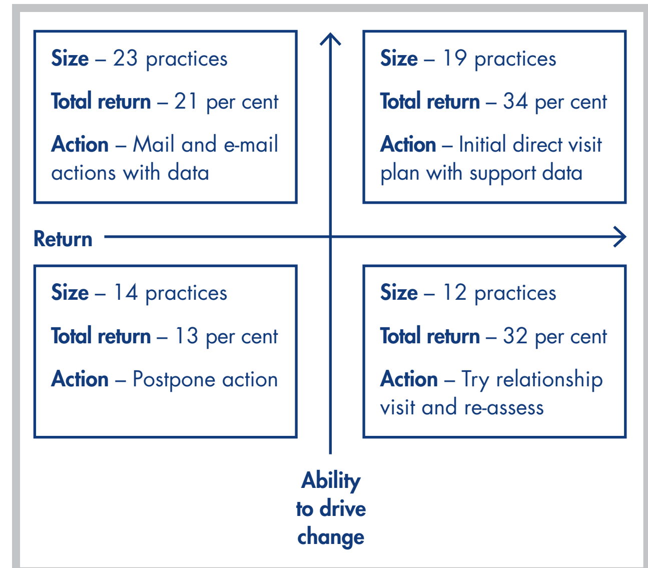
It is not necessary to have three segments; and you may wish to have more or less. However, you should only introduce more segments if you intend to approach them differently.

The highest value group could generate the most return on your investment so you can potentially spend the most on driving change. The highest cost mechanism and the most effective method you have at your disposal within this group is working directly with them and visiting them a number of times.

The lowest group for some products need no action. However, for other products you should consider a low-cost (but potentially low-impact) mechanism for communicating with them. Low-cost channels include mailings or e-mails. Although they are low-cost and low-priority they should still be clear and effective to drive the maximum potential for change.

What you do with the middle group of practices is difficult to define, but you should not consider activities purely on their cost, but rather activities which depend on the return you think you might achieve. These may include customised letters or e-mails followed up with phone calls or one short visit, group meetings or even ‘opportunistic visits’. These choices will be determined by your experience of what appears most effective. The impact of communication efforts should be recorded and used to inform later decision making.

Another driving factor in your segmentation may be the difficulty of driving change, or even gaining access to certain practices, in which case a segmentation may look like this:



Always consider the cost of the activity, taking into account your own time, and then balance that against the value of any potential cost savings and the willingness to change. Determining your approach to the segments you have defined will allow you to plan action which is not only effective, but also cost-effective.

Once you have determined which practices you will visit and the initiative you are going to take to them, you need to plan your visit strategy. This is outlined in the following section.

SIX

Visiting the Clinicians

Direct communication is expensive, particularly if you have not yet established a constructive relationship (outlined in section 8) with the clinician you are engaging with. The suggested process outlined below includes at least four meetings with each target practice, and also requires the production of two or three marketing pieces and one or two letters. Altogether, this may be an investment of several days of your time. Knowing the overall cost of one day of your time will allow you to determine whether this approach to a particular practice/ message combination will provide returns which are greater than costs. If not, you will have to consider lower cost mechanisms of delivery, or covering perhaps two or three changes at the same time. However, this can dilute the main message and hence reduce its impact.

Studies of human communication[3] have illustrated that there are three basic elements in any face-to-face communication:

- Words;
- Tone of voice;
- Body language.

These three elements account differently for the meaning of messages: words account for seven per cent, tone of voice accounts for 38 per cent, and body language accounts for 55 per cent of the message.

These three parts need to support each other in meaning: they have to be "congruent". When communicating face to face, be aware of your own body language and that of the clinician. Ask yourself questions which are appropriate to who is speaking and what they are saying such as:

- Are you actively listening?
- Are you empathising with their concerns?
- Are they engaged with your discussion?
- Are they excited or frustrated?

Using these clues will not only ensure that you are making the appropriate impression on the clinician, but inform your decision to move the discussion on to the next step.

Build a relationship

It is likely that you have already established excellent relationships with your practices, in which case this step may be simplified. However, it is critical to ensure that you have a good working relationship with all the practices you 'own'. Without this relationship, driving any change is going to be even less cost effective – or may even be a waste of time. The NAO report shows the relationship between GPs and prescribing advisers to be generally positive. Fifty-one per cent of GPs describe their relationship with their prescribing adviser as good, and forty per cent describe it as reasonable. Only nine per cent describe it as poor.

If you have been in your PCT for a while, you may not need to go through this step, but for those practices that may be new to you, don't attempt to get them onto your agenda straight away. Just get to know them and to understand their needs and concerns. However, consider your relationships carefully. The NAO report shows that prescribing adviser's assessment of their relationships with GPs was more positive than the view of the GPs themselves, with ninety seven per cent of prescribing advisers describing it as good and the remainder saying it was reasonable.

3 Albert Mehrabian, (1971). Silent messages. Wadsworth, Belmont, California.

You should strive to be considered as a 'trusted adviser' by the GPs. The NAO report shows that GPs tend to see prescribing advisers as more useful than objective. This differs from the prescribing advisers' view, which places their role and that of the medicines management team highest on usefulness and second on objectivity. Increasing GPs' assessment of your objectivity could result in greater impact. This level of trust can be built over time, both by discussing balanced arguments around the overall benefits to patients, clinicians and the local health economy. However, it is equally important to see your role as that of a partner, and to ensure that you have a sufficient degree of flexibility to balance the needs of the PCT with the needs of the practice.

The relationship process

1 Assess the stage of your relationship:

- Are you known to them?
- How do you believe yourself to be perceived?
- Ask them for feedback to assess a potential approach.

2 Send a short letter introducing yourself

- A little background on yourself;
- A short amount of information about your role;
- Careful positioning statement of why you may want to meet;
- Ensure it is about dialogue and not policing or trying to enforce;
- Try to understand their typical working day and week to identify the best time to communicate.

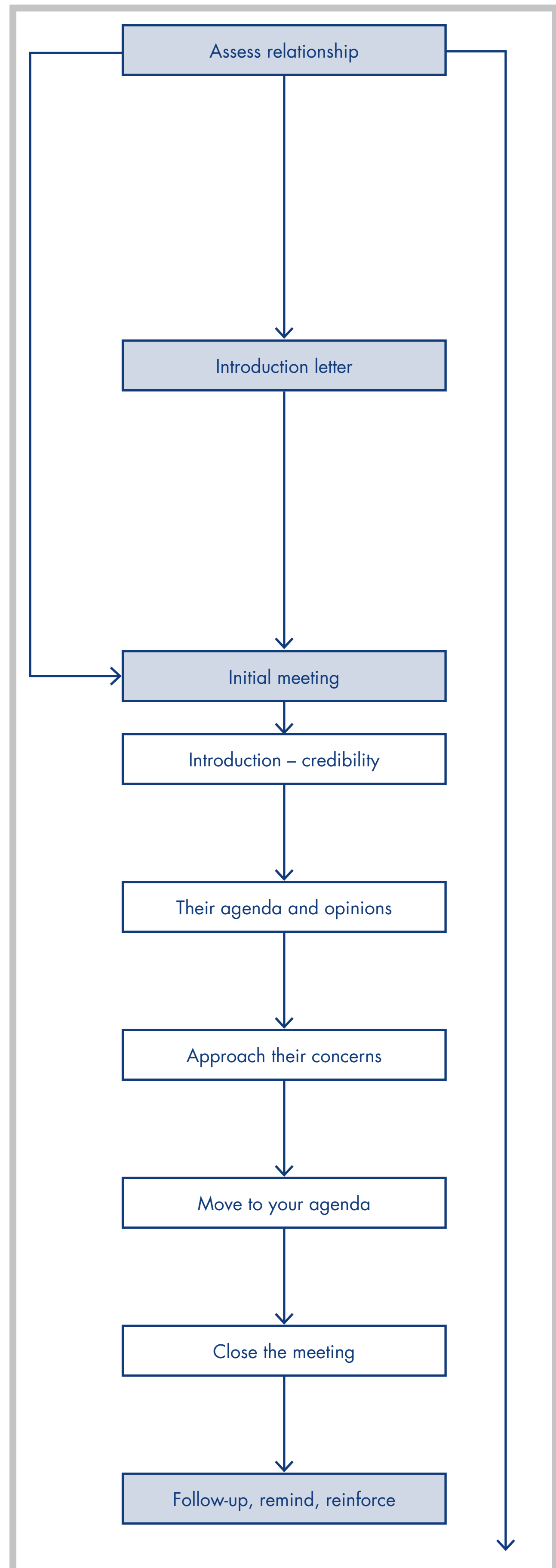
Meeting with the clinician:

3 Introduce yourself

- Opening rapport to put the clinician at ease;
- Establish some credibility; tell them about your background;
- Go armed with some 'hot topic' of interest around prescribing and be able to talk knowledgeably.

4 Ask them about their practice and listen…

- What prescribing advice do they need?
- What do they think you can do for them?
- Historically what has been their relationship?



5 Empathise with their concerns
   - Make sure you have understood each key point;
   - Acknowledge their concerns, do not trivialise them;
   - Ask them if there is anything you can do;
   - Be clear to identify anything appropriate you can do for them;
   - Record concerns and deal with them.

6 Spend a little time explaining that your job also involves looking for ways to ensure that the best possible outcomes across the local health economy are achieved given the overall resources available:
   - Ask them if you can come back and discuss some specific ideas you have.

7 Close the meeting with a clear list of:
   - Concerns from the prescriber;
   - Any background information which you can use to continue your conversation next time you meet;
   - Agreement for your next visit.

8 Send a short letter or e-mail thanking them for their time and reinforcing what you talked about or agreed to do.

If this meeting has not gone well you might want to consider:

- Another relationship meeting, although with no potential purpose this can start to feel like a fruitless exercise, for both the clinician and you;
- Finding a reason to go back by providing something of interest to the clinician, even if it is not on your current agenda;
- Trying another prescribing adviser who might get along better;
- Re-prioritising the practice and concentrating on the 'next on the list'.

Additionally, after your initial meeting, you may want to ensure that you have the right target contact for your activities within a practice. With the rise of non-medical prescribing, there will be other clinicians targeted by the industry (such as practice nurses) with whom new relationships need to be built.

In addition to the activity outlined above, building deep trust and empathy should involve both you and the GP understanding the pressures and issues of each other's role. As such, you should seek to understand the dynamics of a consultation and the conflicting tensions within a practice. This could be achieved by spending at least one session a year sitting with a GP, seeing the type of patients who visit their surgery. The purpose of this is not only to see the diverse mix of patients, their cases and histories, but also to understand the dynamics of the consultation and the factors that influence clinicians' behaviour. The very fact that you have done this at the practice will enable you to speak with greater authority.

Getting your plans adopted

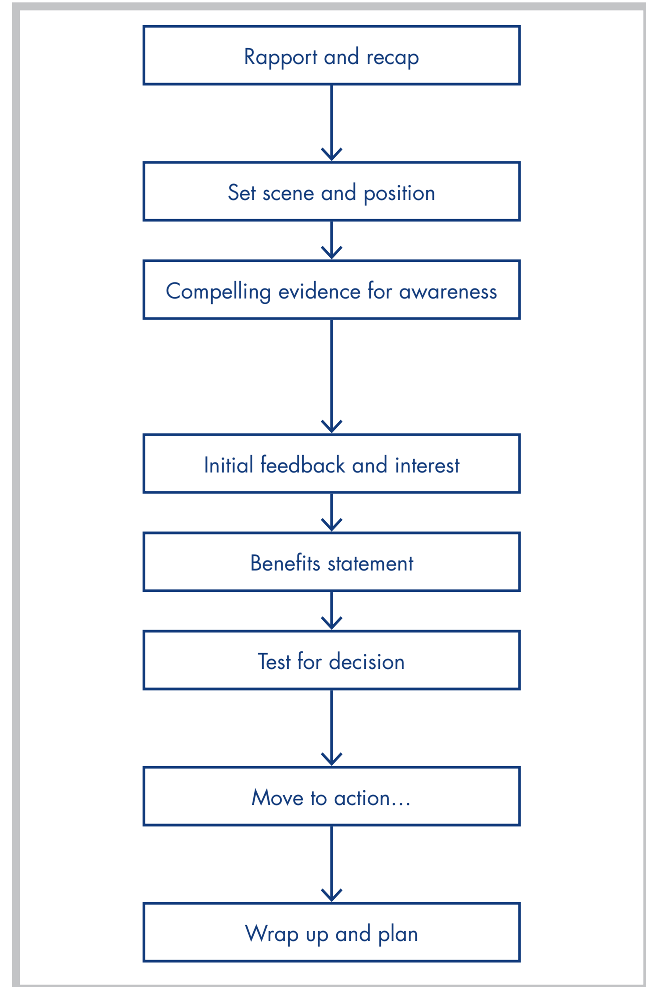
If you have built a strong relationship with the practice, you should then seek to help the clinician move through a typical adoption model such as AIDA:

- Awareness of the issues and potential;
- Interest in making some sort of change and engagement with the process;
- Decision to make a change;
- Action of making a change.

Depending on the depth of your relationship with the clinician and their awareness of the issues around a medicine, you can accelerate the process and achieve most of the above in one meeting. In order to avoid damaging your relationship by rushing the process, you may wish to spread the four simple stages outlined below over more than one meeting.

Before progressing to the next stage of meetings, you need to ensure that the material you are going to put in front of the clinician includes specific benchmarks and information on their practice and your target medicine. Throughout the meeting, let the clinician speak, and listen to all their concerns. Additionally, you should ensure that the meeting flows on from the last time you spoke. This will move the discussion on and start taking the clinician through the AIDA process.

- Establish rapport at the beginning of the meeting and ensure you have sufficient time for your agenda;
- Recap what you discussed last time;
- What you have done about the concerns that were raised at the last meeting;
- Remind them that you asked whether you could come back and talk about any issues around cost-effectiveness;
- Present them with the tailored communication piece. You may choose to present the data anonymously. However, named data may have more impact. Include:
    - Benchmarks against other practices in the area or PBC group;
    - Benchmarks against national averages.



- Ask them to comment on why their practice is different from the benchmarks;
- Comment on what savings and potential benefit to patients might be achievable for the practice, and the impact this will have on the local health economy;
- Ask them whether they think it is possible to change, and ask what it might take to achieve;
- Ask whether there is anything that you can do to help them;
- Thank them for their interest, and say that you will get back to them with:
    - The latest guidance;
    - Information about other practices and what they have done;
    - What assistance you can provide;
    - What kind of benefit the clinician, the patients and the local health economy would gain from making a change.

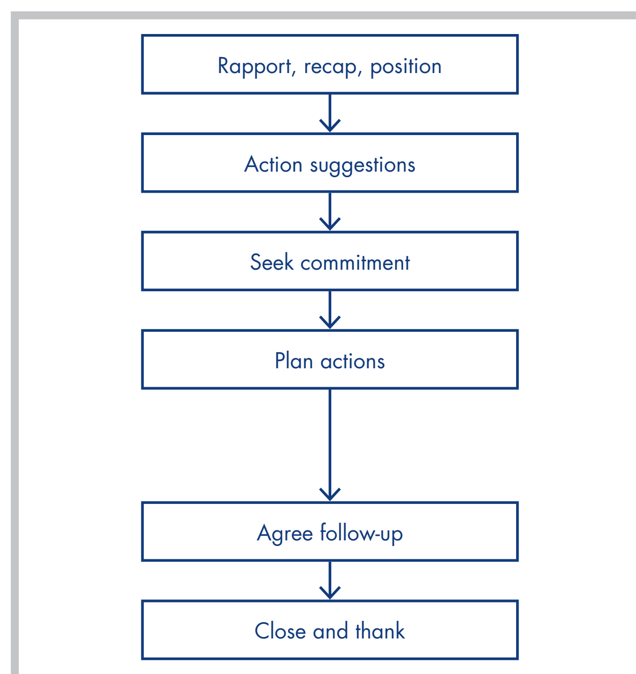
Getting the agreement

Ensure that you have the appropriate materials to hand to support your arguments, and help the clinician through any potential barriers.

- Summarise where you left off;
- Outline what you think could be done based on evidence and information you have gathered from:
    - National guidance;
    - Local best practice;
    - Secondary care endorsement for changes;
- Ask for their opinion and agreement;
- If they are willing and able to change:
    - What level of change (existing patients, only new patients etc.);
    - What process are they going to use to achieve changes;
    - What timescale will they work to;
- Look at the data again and agree a target change as well as a date for review;
- Ask whether they have everything they need to go ahead with a change.

If they are unwilling or unable to change try to uncover the core reasons as to why they will not change. If possible address their concerns at the time and seek confirmation of satisfying the clinician before seeking commitment. If you are not in a position to deal fully with the underlying reasons for non-commitment at that time, schedule another appointment over the coming weeks which will give you time to compile the necessary information. It is important not to be perceived as aggressive, this is a common complaint for GPs when dealing with representatives. However, if this further effort does not yield results choose either to walk away on this occasion, or to be a little more forceful. Additionally, it they are part of a PBCG, you could potentially use any available pressure from others in the group to help drive a more effective use of resources. Finally, they have obligations under the QOF, as outlined in the introduction.

Following the meeting, send them a letter outlining the agreement you gained. You should also include what you and the practice are expecting to deliver, the timescale and the date for a follow-up meeting.



Supporting activities

There is a full spectrum of support that the PCT can provide to practices and clinicians in order to help drive change. These can take the form of:

- Incentives to help offset the additional work of making changes;
- Financial assistance with particular specific costs;
- Information and guidance around specific issues;
- Administrative support (secretarial, nursing, pharmacy etc.);
- Letters to patients.

It may be appropriate to spend a significant amount on helping the change through – if the return on investment justifies this. It is critical that as part of your planning you seek to understand the potential gains of a change (as outlined previously in this section) and hence understand the amount you are willing to spend in order to drive this change.

Two examples of the possible supporting activities are reproduced from the NAO report:

When the NHS's 'Better Care, Better Value' indicator for efficient statin prescribing was launched in September 2006, only 19 per cent of Rochdale PCT's statin prescribing was of low-cost statins – the least efficient in England. However, Rochdale[4] subsequently achieved the largest improvement in statin prescribing efficiency in the country over the next three months, and by December 2007 almost 45 per cent in Heywood, Middleton and Rochdale PCT was for low cost statins. Rochdale's medicines management team attribute this improvement to the deployment of a range of tactics, including:

- **a prescribing incentive scheme;**
- **employing pharmacy technicians to work in GP practices to assist in switching patients' medication;**
- **extensive benchmarking at a practice level and also against PCTs with similar demographic profiles but more efficient statin prescribing;**
- **sending letters to patients explaining the statin switching policy.**

Practice-based support can produce financial savings and encourage GPs to prescribe efficiently.

In New Forest PCT and Eastleigh and Test Valley South PCT each of the 38 practices, covering 350,000 patients, was given dedicated pharmaceutical support to assist with its medicines management policy. The PCT employed eight full time equivalent pharmacists costing in the region of £400,000 created savings of more than £1.1 million by encouraging the compliance of patients with their medications and supporting practices in changing prescribing habits.

In Bristol North PCT practices received pharmacist support in proportion to the size of their prescribing budgets, from four hours of support a week for practices with budgets less than £750,000, up to 12 hours per week for practices with prescribing budgets of more than £1.2 million.

PCT provision of administrative support for practices encourages GP participation in medication switching. New Forest PCT adopted a policy of switching statin prescriptions to generic simvastatin. Some GP practices were concerned about the workload involved in changing several hundred patients' prescriptions. Practices were provided with template letters to patients whose medication would change, explaining the reasons for it. In some practices patients were given the phone number of the medicines management team and invited to ring them if they had any queries. In 2005-06 generic simvastatin prescribing increased from less than 50 per cent to 75 per cent of statin prescribing.

Not all target initiatives will necessarily require a high level of spend. However, when planning your targets you may want to agree the level of budget you have at your disposal to assist the individual practices. You should ideally calculate the cost of all types of potential assistance. These costs may include everything from the price of a few stamps, to employing contract resources to drive effective change within individual practices.

4 From October 2006, Rochdale PCT was incorporated into Heywood, Middleton and Rochdale PCT.

You should seek to gain the commitment for the necessary spend before engaging with practices. This will enable you to agree actions directly with the clinician, rather than go backwards and forwards between the practice and your budget holders. This never helps the relationship between you and the clinician, who wants to work with someone who can actually make decisions. As such, you should create a simple business plan for agreement by the PCT, where you outline:

- Target initiative;
- Likely savings/benefits for patients;
- Action plan in terms of targeted practices, timescales, requirements, etc.;
- Investment required (supporting actions, your time etc.).

Creating the business plan will help you understand the needs, and the case for expenditure, and also to gain commitment for this expenditure. However, the scale and scope of the business case should be consistent with the amount of expenditure. A number of changes have failed in the past for want of a tiny investment (stamps, envelopes, etc.) for which a detailed business case may be unnecessary.

Follow up and monitoring

Before the meeting, collect and analyse the latest data on the practice's achievements against targets. At the start of the meeting you should, as always, thank the clinician for giving you their time and catch up on where you left off. After you have created a good level of rapport you should ask them their opinion of progress against the initiative. You should follow this by presenting the latest data, and ask them again for their comment.

If the initiative is being successful:

- Thank them;
- Reinforce the benefits for practice, patients and the PCT;
- Ask them if they think they can go further and if so discuss a new, more challenging target;
- Ask for their agreement for you to return again soon to talk through progress and any other issues.

If the initiative is not being successful:

- Ask them for their opinion of the reasons;
- If possible, address these reasons;
- Ask if there is anything you can do to help?
  - Set a new target?
  - Gain support from elsewhere in the local health economy?
  - Thank them and invest your time elsewhere?

It is probably advisable not to attempt to move on to a new target medicine during this meeting. As always, you should follow up the meeting with a letter summarising your discussion and outlining any agreed follow-on actions.

It is useful to create a small 'dashboard' of medicine targets and initiatives, and to update these on a regular basis to understand the performance against these targets by individual practices. This will allow you to provide practices with the latest benchmarks by phone or email to help ensure old targets do not slip.

Move on to new targets when you feel you have made significant progress with an old target, and the practice feels that most of the initial difficulty of the change is over, and that they and their patients are receiving the benefits.

SEVEN

Communication materials

There are estimates that suggest that people only remember 10 per cent of what they read and 20 per cent of what they hear. But fifty per cent of what they read and see together, and 70 per cent of what they say themselves. Although these figures are approximate, the message is clear – well presented materials used in conjunction with conversation with the clinician and with the appropriate body language (please see Part 1 and the Introduction) will be significantly more memorable, and will help to drive change. Relying on spoken or written communication in isolation will not have the same result.

The communication materials

The materials which you produce should mirror the approach you are using with the clinician. For instance a letter should be composed completely differently from a piece you will talk them through in person. Additionally, it is important that the materials are tailored to the stage of discussions you are having with a clinician. For instance, it is obviously inadvisable to send out a list of actions whilst you are still building the relationship.

Materials (including letters) should be clear and concise, making a few points clearly. There are published studies which show that three key points is the most effective. Confusing the objective with too many products or issues at the same time will not be constructive. Information should be specific and should be tailored to the practice to which you are talking – unless it is a broad coverage intended for all practices, which will probably have less impact. Ideally, you should seek to be consistent in format and style between all your communication pieces. Your own branding helps the clinician immediately identify the origin of the piece and to find their way around it. Additionally, written communications should have plenty of "white space" and use bullet points and short sentences to aid readability. Further information, or more detail, can be supplied in an appendix or supplement. Finally, all pieces should reinforce and build on previous communications. This does mean that you need to have a simple mechanism for keeping and filing all communications you and others have created and used.

We know, and this was highlighted by the NAO report, that clinicians are exceptionally busy and are constantly bombarded with information from many directions. It is therefore not only important to tailor your communication to be specific, but also to ensure that you are not handling ambiguous data or guidance. It was observed in the NAO report that:

- PCTs often attempt to remove these ambiguities in adapting the guidance notes to the local context, making the PCT guidance notes less technical and clearer to follow. This process involves prioritising some options and removing others. This might be based on the clinical needs of the local population, but can also be motivated by budgetary constraints of the PCT.
- Through this process of prioritising some options, the information becomes useful, but less objective, especially as GPs often consider PCTs to be mainly driven by a budgetary agenda.
- For example, in the focus groups run by RAND Europe, one GP said that information from the prescribing adviser/PCT was 'dominated' by budgetary concerns, and several GPs felt that information that took into account cost pressures as well as clinical outcomes could not be objective.

At the core of your relationship must be trust, and your communication must not simplify and shift the argument in your favour by representing only half the evidence or guidance.

Making a compelling case means providing your information not only with specificity and honesty, but with the weight and endorsement of key influencers in the local health economy. A focus group in Northumberland PCT commissioned for the NAO report showed that using the power of the local opinion leaders can help mitigate concerns that cost pressures are taking priority over quality. This PCT communicated messages to GP practices by working with five GPs whom it considered effective in influencing the prescribing behaviour of their peers.

Communication pieces and suggested content

You may produce a number of different communication pieces which are all for different purposes. Some of these may not be appropriate depending on the maturity of your relationships with the clinicians. They may include some of the suggested contents outlined below:

1 Broad coverage letter to all practices

- Introduction and personalisation of this somewhat impersonal channel;
- Introduction of team and roles;
- Past activities and successes;
- Visiting process;
- Objectives of a visit;
- Who to call and who may call you.

2 Data analysis aids to be used during face to face meetings, outlining the issues designed to move the clinician to awareness and interest in change

- Overall practice activity in terms of specific medicines;
- Outline of benefits of change:
    - Benefits to patients;
    - Potential savings to the local health economy;
    - Benefits to practice (better satisfied patients, incentive schemes, etc.);
- Overall PCT prescribing activity of target medicines;
- This practice's spend compared to other named practices in the PCT or PBCG.

3 Support piece designed to help clinicians move from interest through to decision and action. This should include:

- What benefits are there for the patients, the NHS and the clinician;
- Evidence of why a change would generate benefits;
- Support for a change from guidance, and where possible secondary care endorsement – preferably a source known to the clinician;
- How the change has been made elsewhere and what impact it has had;
- How you can support the change;
- A suggested plan of action.

4 Follow-up letters

- Thanking clinician;
- Outlining benefits;
- Follow-up actions with milestones and measurables;
- Future monitoring plan;
- Scheduling information for next visit.

Benchmark data, ePACT and the PSU

According to the NAO, 70 per cent of GPs report that they are influenced by benchmarking data. Using appropriate benchmarking data brings the behaviour of practices into a local and national context. Benchmarking can provide the basis for making clinicians aware (AIDA), of the potential for change, but also allow them to understand the potential outcomes of any actions (AIDA).

ePACT data provides the best possible source of this data and ePACT.net can be used to profile practices by cost and frequency of prescribing. The practice cost profile and practice items profile report template and BNF cost profile template are good starting points for analysing practice prescribing performance. They can be applied against any BNF selection to analyse cost, or frequency of prescribing by a number of parameters. These reports allow you to readily identify practices in the PCT whose prescribing differs from the target.

Epact.net is accessed at http://www.epact.ppa.nhs.uk/systems/sys_main.htm.

Additionally, many of the analyses that you would wish to perform, may be easily accessible from the Prescribing Support Unit (PSU) website.

The PSU is a part of the NHS Information Centre for Health and Social Care (www.ic.nhs.uk/psu) and provides a range of guidance. The PSU produces prescribing indicators from PPA data to measure the performance of PCTs and practices. These are accessible through the ePACT website (www.epact.ppa.nhs.uk/systems) as part of the Prescribing Dispensing and Financial Management system.

Standardised measures of prescribing volume, such as the number of defined daily doses (DDDs), or average daily quantity (ADQs), allow prescribing patterns between practices or PCTs to be assessed on a more comparable basis than is possible by directly counting 'items'. These volume measures can be compared across practices using age and sex weighted patient denominators (ASTRO-PUs and STAR-PUs) to examine prescribing overall, or within specific medicine groups.

Data can be extracted from the ePACT and used in other applications to create tailored information for practices, clinicians and commissioners.

Standard information available from the ePACT website includes:

- Potential generic savings;
- Specialist medicines ;
- Prescribing indicators;
- Medicines of limited clinical value;
- Simvastatin/Pravastatin as a per cent of total statin prescribing;
- A range of 12 specific indicators (e.g. Benzodiazepines (ADQ/STAR-PU));
- Volume comparators, measured as ADQ/STAR-PUs across a range of 20 different therapeutic groups;
- Cost comparators, measure as NIC/STAR-PU across a range of 14 markers;
- Population data;
- Mortality – all causes, CHD, Stroke and all circulatory diseases;
- IHD and LISI (Low Income Scheme Index) scores;
- ONS area classifications.

This is presented by quarter and available as a graph or raw data, with the detailed medicine list and PU weightings. Comparisons are available quarter-by-quarter for:

- Practices within a PCT;
- PCTs with others in the SHA;
- PCTs with others in the "PCT cluster" which are identified as having similar population characteristics.

Information from the National Prescribing Centre

The National Prescribing Centre (NPC) is an NHS body in England, funded by the Department of Health. It promotes and supports high-quality, cost-effective prescribing and medicines management to improve patient care and service delivery. It has a strong reputation for the quality and value of its work programme, which covers the provision of evidence-based information, education and development and good practice guidelines. It can provide an extremely useful source of accurate up to date information on prescribing.

The NPC portfolio currently includes:

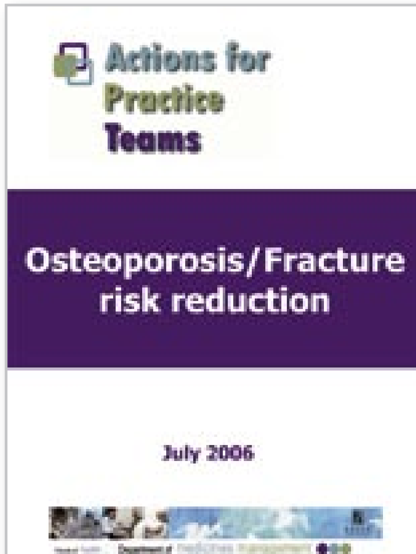
- MeReC Publications (i.e. Bulletins, Extras and Rapid Reviews), which are made available to all GPs, pharmacists and other relevant clinical professionals;
- On the Horizon Publications, which provide planning information to key NHS professionals and managers on significant new medicines (or indications) in advance of their launch;
- Evidence-based therapeutic training workshops delivered to a wide range of clinical professionals;
- Effective medicines management and the implementation of change;
- Good practice guides, in areas such as Controlled Medicines, Concordance, Repeat Medication Management and Area Prescribing Committees;
- Conferences and other events covering relevant current issues.

In addition, the NPC is developing two major new strands of work to help further improve the access and relevance of its outputs. In the near future, it will be launching NPCi, a completely new, web-based approach to the provision of medicines-related information, education and training. This will be supported by the development of a supported network of individuals with a special interest in therapeutics and medicines management across all PCTs in England, called the NPC Associate Programme.

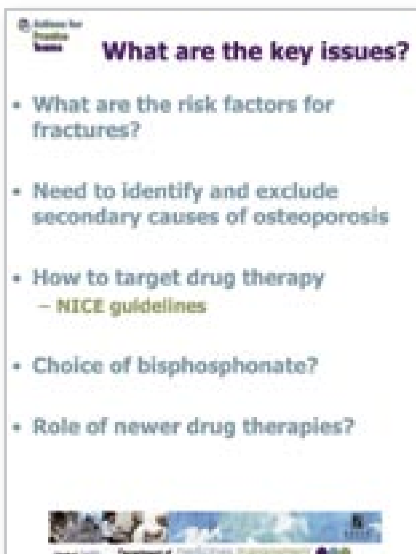
Nearly all NPC outputs are made available on its website, together with a range of more interactive support (such as the electronic 'Current Awareness Bulletin' [eCAB]) which can be subscribed to free of charge. New NPC activities will be flagged up first on their website, which can be visited at www.npc.co.uk.

Sample communication piece

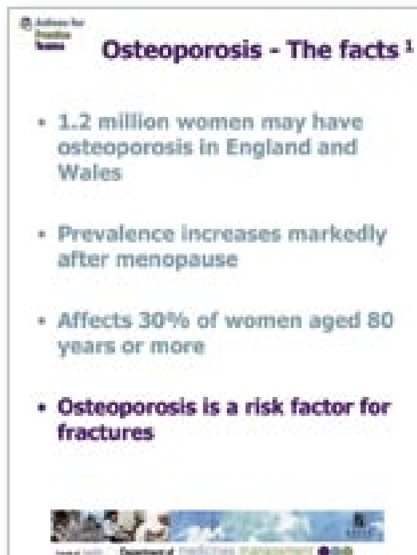
The following sample communication piece was developed by the Department of Medicines Management at Keele University. It illustrates some of the key points of good communication. This sixteen-page document has a style you may wish to consider when communicating face to face with a clinician.

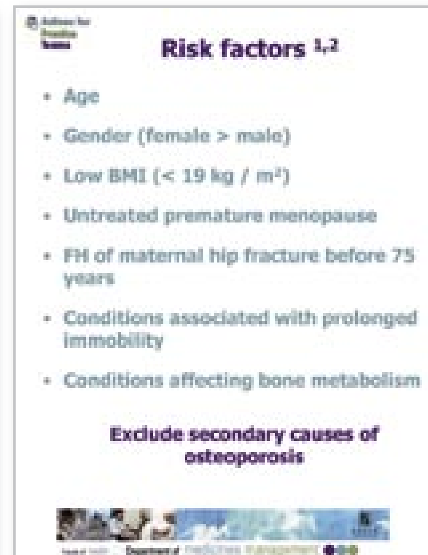


- This is a discussion guide, providing structure and guidance and corresponds to document type 3 discussed in Chapter 7.
- It is clear what this is from the title.
- Clear branding is established from the title page:
  - What series this is (Action for Practice Teams);
  - Branding (Department of Medicines Management);
  - Establish the colour scheme;
  - Consistent type faces;
  - Clear, unfussy approach.
- All of these facets of the document are continued on each of the following pages.

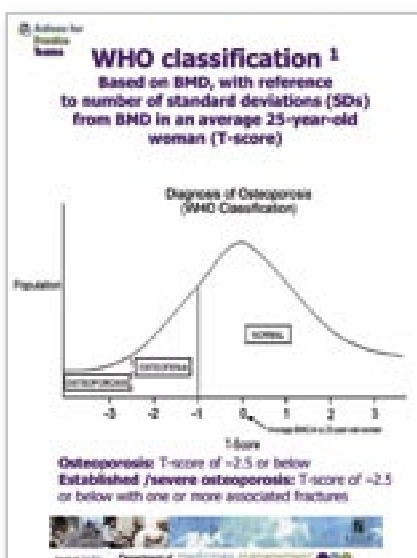


- This discussion guide is quite different to the format of a letter and uses plenty of white space and bullet points for greater impact (see Chapter 7).
- Clear statement of what the story is and sets the scene for the meeting.
- It does not start by giving the conclusions and guidance regarding which Bisphosphonate to use.
  - It is inappropriate to make conclusions without taking the clinician through the AIDA process.
- Clear branding and communication style continued on this and every page.





- The first slide shown above raises the **awareness** of the issues and scale of the problem with supporting epidemiology;
- The end of the first slide (above) and the second slide seek to drive **interest** in managing osteoporosis. In addition, the use of highlighting stresses the impact of osteoporosis, making a case for **action**, by:
  - Outlining the relationship between osteoporosis and fracture.
  - Highlighting the impact of hip fracture on mortality.
- The third slide above helps the clinician start considering their own real patients, and how these might be at risk. This makes the issue 'live' for the clinician, and will move them to make **decisions** around increasing their own management of at-risk patients.
- The first slide below starts to drive the clinicians to **action** using an accepted and recognised independent classification system;
- The final slide below outlines a number of options for **action**, the efficacy and appropriateness of which will be explored in the next group of slides.



Eligibility Criteria for Pharmacological Osteoporosis Treatment (Based on current & draft NICE guidelines 1,2)

- This slide presents the guidance from NICE around appropriate treatments. It is clearly laid out in a useful format.
- The clinicians should now be engaged and interested in hearing what they can do to help prevent fractures in their patients;
  - It moves the clinician to the agenda of which treatments are appropriate in this market;
  - It becomes a useful reference to assess patients for pharmacological intervention if left with the GP;
- The slides below clearly outline each treatment choice;
  - Carefully highlighting key points;
  - Each statement is referenced, and the references are supplied later in the document;
- Includes not only evidence supporting efficacy but also cost issues.
- Please note that each slide continues to use the same branding, colour schemes, fonts and similar layouts.

Calcium and vitamin D [1,4]

Consider calcium 1000mg and vitamin D 800IU for patients at highest risk

- Frail, elderly people (average age 84 yrs) in nursing or residential homes for primary prevention (NNT = 36 [over 3 years] to prevent one hip fracture)
- Adjunct to anti-resorptive agents such as bisphosphonates

NNT to prevent a vertebral and non-vertebral fracture over a period of 2 years [6]

Baseline risk estimated from pooled estimates from trials of patients with normal bone density (low risk) and trials that enrolled women with low bone mineral density (high risk)

Give priority to secondary prevention (high-risk) patients

Choice of bisphosphonate [1,5]

- Generic alendronate is already nearly half the price of Fosamax® – consider as first-line choice
- Only alendronate and risedronate reduce incidence of hip fractures (NB hip fracture is associated with ↑ mortality)
- Alendronate, etidronate and risedronate are similarly effective in preventing vertebral fractures
- Lack of head-to-head comparisons for bisphosphonates

Fosavance [9]

- Once weekly preparation launched after Fosamax patent expiry (way of extending patent life of drug)
- Contains alendronate 70mg and vitamin D_3 2800 units - Patients may still require calcium
- No evidence that it is any more effective than alendronate alone. (Evidence base is from alendronate)
- Nearly double the cost of generic alendronate (NB alendronate Cat M drug - price may reduce further)

Ibandronic acid [7]

- Reduces risk of vertebral fractures in postmenopausal women
- Efficacy in reducing hip and other non-vertebral fractures has not been established
- No comparative trials with other standard treatments
- No confirmed evidence that monthly dosing improves compliance
- No clear place in therapy

Strontium ranelate [8,3]

- Reduces the risk of new vertebral fractures and non-vertebral fractures compared to placebo
- Unexpected adverse effect – increased risk of VTE
- Reserve second-line for patients unable to take bisphosphonates
- Patients should receive calcium and vitamin D if dietary intake inadequate

The document concludes with two critical slides:

- The first is a call to action which boils the messages from the presentation down into five key points regarding:
  - Consistent diagnosis through DEXA scans;
  - Where to prioritise treatment;
  - Which supplements to use;
  - Which Bisphosphonate to initiate with;
  - Where switching may be appropriate.

Importantly, the whole document is supported by evidence for which references are provided.

- This helps to ensure that your messages are considered powerful, accurate and objective.

EIGHT

Managing your information

Pharmaceutical companies use Electronic Territory Management Systems (ETMS), or Customer Relationship Management (CRM) systems, to collect and share information on customers. Within a pharmaceutical company these systems are used for a variety of purposes, such as:

- Recording clinicians prescribing habits;
- Monitoring the performance of the sales representative in terms of activity;
- Coordinating the activities of the sales representatives;
- Providing a basis for analysing the impact of visits to clinicians against sales data for that area;
- Keeping information about individual clinicians including:
    - Their name and address;
    - Additional profiling information;
    - Their target status;
    - The level of contact through calls, meetings, mails etc.;
    - Specific requests they have made.
- Tracking of representative activity to ensure compliance with appropriate ethical behaviour and professional codes of practice;
- Sharing of information throughout the organisation;
- Providing a consistent source of continuity information if disruptions or changes occur in the company.

Collecting and storing information

In order to make your work more focussed and efficient, you should define a mechanism for storing the following information. Unlike in pharmaceutical companies, there are relatively few people who need to access the information, so storing the information on a shared drive or a computer in the office should be appropriate. Aim to keep the data in simple files (excel, word etc.) stored in an orderly manner and dated after the last update.

A simple system in these situations is almost always better than a complex one. Many pharmaceutical companies have discovered that adding feature after feature to their CRM systems has rendered them overcomplicated and at times unusable or unused.

Information that would be appropriate to keep and maintain:

- List of practices and clinicians within them;
- Who are the main decision makers within a practice;
- Who amongst the prescribing advisers is responsible for each practice;
- Who the key influencers or opinion leaders are for each practice;
- Information from your joint scoring sessions;
- Selected highlights from benchmarking analysis;
- Target or priority status;
- Current activity against each practice;
- Current concerns of physicians within each practice;
- Current stage of uptake;
- Agreed action plans with milestones and dates.

It is important to ensure that whenever you have interacted with the practice, performed new data analysis or gathered a useful piece of information, you update the data stored. This ensures that at all times the information is up to date and in a readily available format.

The Freedom of Information Act

Some of the processes outlined in this document require the collection and storage of information on GP practices within your PCT. As the information you collect may be of interest to members of the local health economy and pharmaceutical companies, you need to consider your responsibilities under the Freedom of Information Act 2000.

The Freedom of Information Act 2000 (the Act) gives individuals the right to request information held by public authorities (which are defined in the Act and includes PCTs). Requests for information must be in writing and must be dealt with within 20 working days. The requestor does not have to refer to the Act in their request. The Act covers all the information held by the public authority – including paper and electronic documents and records, administrative information and correspondence, working paper files, and emails.

Some information requested may be exempt from disclosure. The Act provides a range of statutory exemptions which can be considered. For example, information may be withheld because it is personal information or because it is commercial in confidence. The application of many of these exemptions is subject to a public interest test: the public interest in withholding the information is considered against the public interest in releasing the information.

The information belongs to the PCTs and it is for the PCT to decide what action to take in response to a request for information. Ultimately the PCT is responsible for the data and is accountable to the Information Commissioner's Office for its decisions in relation to requests under the Act.

NINE

Review and revitalisation of your plans

The activities outlined in this document should not be performed only once. Instead, the inputs to the process (the targeting, materials, etc) should change in response to the output of the process (prescribing behaviour). Moreover, the environment in terms of new medicines, generics and clinicians will continue to change. It is therefore critical to put together a plan for reviewing and revitalising your activities, so that you continue to focus on optimal return on investment.

When creating this review plan, you should attempt to include what the activity is, who it involves and how regularly it takes place.

A plan may look like this (see below):

This does not represent all possible activities, and the timings and tasks are merely examples.

Initiative	Cycle	Med. Mgmt Team	PCT Board
Review and update data storage	Weekly		
Review progress with each practice	Monthly		
Review expenditure and relate to budget	Monthly		
Review overall targets by practice and medicine	Quarterly	✓	✓
Review practice targeting	Quarterly		
Review and redefine medicine targets	Quarterly	✓	
Horizon scanning and planning	Quarterly	✓	
Plan and review business cases	Quarterly	✓	
Review practice ownership	Half-Yearly	✓	
Present business cases for initiatives with supporting budgets	Half-yearly	✓	✓

TEN

Conclusion

In this guide we have considered and presented ideas and suggestions for enhancing the effectiveness of your communication with clinicians. We have considered:

- Where to place your effort – simple targeting of practices and initiatives;
- How to build better relationships with your clinicians;
- Communication strategies – how best to drive adoption;
- Communication materials – the 'look and feel' of documents and information;
- How to manage the information.

You should view the contents of this document in the wider context of your role, and be wary of following the guidance as if it were an exact recipe for success. If your judgment suggests that any of the techniques may diminish the trust you have developed with clinicians, or are not in the best interests of patients, do not use them. We have used a number of sales analogies, and as a nation we are generally distrustful of sales people. You should be careful of taking these analogies too far, or using too much jargon. Ultimately, you are seeking to work with and assist clinicians so that patients derive maximum benefit from their healthcare providers.

Greencoat is produced using 80% recycled fibre,
10% TCF virgin fibre and 10% ECF fibre

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