NHS SCOTLAND

Review of Prescribing Improvement schemes 2013

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Report commissioned by Quality and Efficiency Support Team Scottish Government Health and Social Care Directorates

Contents

REVIEW OF PRESCRIBING IMPROVEMENT SCHEMES WITHIN PRIMARY CARE 2013

This report is designed for management purpose only

1. Foreword

This review of primary care prescribing improvement schemes was commissioned by the Scottish Government Quality Efficiency and Support Team (QuEST) as part of the National Prescribing Programme (2010 to 2014). Both authors can be considered experts in this field: Douglas Griffin is a former Director of Finance for NHS Greater Glasgow and Clyde and Margaret Ryan is the Chair of the Scottish Prescribing Advisors Association.

The report provides valuable reflection and insight into the range of prescribing schemes used by Boards. The views of the authors support the understanding that Board ownership of joint formularies is vital and that national priorities require local implementation using a multifactorial approach, dependant on the prescribing culture.

The authors and I are most grateful to those colleagues within Boards who took the time to respond to the survey and, particularly, those who took part in the interview process.

I commend this report to you as a welcome addition to the evidence base of prescribing in Scotland.

Kind Regards

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2. Executive Summary

The scale of expenditure and the variation[1] across Boards for primary care prescribing of £1.12 billion for the financial year 2012-13 was the primary impetus for this review. This review details learning from Boards' operation of prescribing improvement schemes and disseminates useful operational knowledge across NHSScotland.

Purpose

1. To review a range of recent primary care schemes used by Boards to improve quality, particularly safety and cost effectiveness, of prescribing practice
2. To identify key contributing factors to success
3. To identify learning points to assist Boards with the design and implementation of future schemes

The following are the key learning points identified from this review:

1. All Boards seek to use prescribing improvement and incentives to contain expenditure growth and promote safe and effective prescribing practice

2. Drug formularies are used as an instrument to establish standards for high quality, cost effective prescribing practice, with a number of prescribing improvement schemes based on promoting and encouraging formulary adherence and compliance

3. Therapeutic substitution is regularly successfully used with a range of approaches in conjunction with schemes focused on promoting formulary adherence for cost improvement

4. Prescribing Indicators (PIs), National and Board specific, are used to establish norms for prescribing practice, and as an instrument to promote consistency of prescribing practice and a reduction in variation

5. All Boards saw effective engagement with GP Practices as fundamental to operating successful prescribing improvement schemes

6. The level of involvement and ownership which GP Practices were prepared to take within prescribing improvement schemes is dependent on local culture and the approach adopted by Boards

7. The principle of making some payment to GP Practices for prescribing improvement work undertaken was almost universally accepted, with a range of approaches to determine the appropriate level of financial stimulus for GP Practices to secure participation

8. The GMS contract was used in all Boards to implement prescribing improvement schemes. The degree of use varied between Boards, dependent on resource availability to develop and undertake other prescribing improvement schemes

[1] ISD Scotland. Prescribing and Medicines: Prescription Cost Analysis. 25/6/13

Conclusions

1. Schemes grounded on formulary compliance, with or without a PI linkage, appear the most durable and likely to achieve a sustainable cost improvement over time

2. A strategic approach should be followed, with joined up complementary schemes in terms of objectives, with clear leadership and management to guard against duplication or overlap

3. There is considerable scope for learning from the experience of different Boards in implementing prescribing improvement schemes within NHSScotland. Culture is a key factor however, and it is important to recognise that **'one size does not fit all'**. Boards require to develop different approaches to achieve the same targeted outcomes

3. Introduction

This report reviews the range of different schemes which have been used by Boards in recent years, aimed at securing improvements in the quality of prescribing practice within primary care. By reviewing the experience of Boards in operating these schemes, key factors to success have been identified. In addition, the report includes a number of learning points which may assist Boards with the design and implementation of future schemes.

4. Background to Review

Expenditure on prescribing accounts for approximately 15 per cent of the overall NHSScotland budget. This led to the establishment of a Prescribing Workstream within the national Efficiency and Productivity Portfolio in 2011. Since then there have been three key papers published. *The New Medicines Reviews (2013)* by Professors Routledge and Swainson which focused on Scottish Medicines Consortium (SMC) and Area Drug and Therapeutics Committee (ADTC) processes, particularly the access to new medicines with safe, effective and cost effective prescribing core tenets. Secondly, the Wilson and Barber Report (2012) on *Review of NHS Pharmaceutical Care of Patients in the Community in Scotland* which has been followed by the Scottish Government response *Prescription for Excellence: A Vision and Action Plan* (September 2013) which aims for every patient to get the best outcomes from their medicines, avoiding waste and harm.

Approximately 70 per cent of expenditure on prescribing is incurred within primary care. It is the scale of this expenditure which has been the driving force behind this review. The intention was to seek to learn from the experience of different Boards on implementing improvements in safe, cost effective prescribing and share these as good practice. It is hoped that this exercise will assist in creating further improvements in the safety, equitability and cost effectiveness of prescribing in primary care across Scotland.

In approaching this review it is appropriate to emphasise that patient safety and prescribing quality are key in prescribing and of primary importance in the design of prescribing improvement schemes. This links the work closely to the aims of the Scottish Government Quality Strategy (2010) and Prescription for Excellence (2013). During the conduct of this review, it was clear that all Boards held this view and had consistently approached the design of prescribing improvement schemes from this perspective. Typically, prescribing improvement schemes focus on the improvement of cost effectiveness or the improvement of other aspects of quality. Reconciling these objectives can prove challenging, particularly where a scheme seeks to deliver on both fronts simultaneously and there is an absence of focus on either. During the process of a scheme design there is sometimes a tension between the need to improve cost effectiveness and the desire to improve safety or equitability which requires resolution. Boards emphasised schemes were most successful where there was a clear strategic approach and a consistency in implementation delivery.

It is recognised that some Boards have been developing and implementing prescribing improvement schemes for many years while others have been doing so for shorter time periods. Boards will therefore derive different learning from this review. For some, the learning may simply be a reassurance that theirs is an appropriate approach.

Local culture inevitably exercises a significant influence on the approach taken by individual Boards and therefore, an outcome of this review is not a single set of conclusions based on a *one size fits all* approach.

Approach to Review

Initially, a questionnaire was sent to all Boards to obtain details of prescribing improvement schemes which they had implemented during the three years to March 2012. This was set out in two parts:

Part 1 asked Boards to identify the main types of schemes they had sought to implement during the course of the previous three years.

Part 2 asked Boards to focus on three schemes in particular and provide the following detailed information for each scheme:

- Brief description of scheme including objectives
- Implementation/approach - main characteristics
- Cost of scheme - annual cost in whole time equivalents staffing and additional costs
- Target outcomes (cost and quality)
- Actual achievement, indicating specific elements in approach which were regarded as particularly effective

Responses were submitted by almost all Boards. This provided sufficient information to obtain a picture of the range and diversity of schemes currently in use across NHSScotland.

The next step was to conduct a series of interviews with a selection of Boards to obtain more detailed information related to their questionnaire submissions and to discuss their general approach and experience of operating prescribing improvement schemes in recent years. The Boards visited were chosen as mainland Boards, with a geographical spread and a mixture of rural and urban populations:

NHS Ayrshire and Arran	NHS Lothian
NHS Dumfries and Galloway	NHS Grampian
NHS Tayside	NHS Greater Glasgow and Clyde

These visits provided detail about the local culture and how this influenced the approaches taken by Boards with regard to prescribing management and the design of prescribing improvement schemes.

5. Overview of Findings

A summary of key findings is provided below:

1. All Boards were seeking to use prescribing improvement/incentives to contain expenditure growth where possible and clinically appropriate.

2. All Boards were seeking to use prescribing improvement schemes to promote safe and effective prescribing practice.

3. The main drivers of quality, safety and cost effectiveness follow NHSScotland strategic documents, in particular the Quality Strategy (2010) and Prescription for Excellence (2013).

4. Drug formularies were being used as an instrument to improve standards of prescribing practice, with a number of prescribing improvement schemes based on promoting formulary compliance, as a route to improving prescribing practice and/or achieving cost improvement.

5. Therapeutic substitution is regularly used in conjunction with schemes focused on promoting formulary compliance and appears to be successful in securing significant cost improvements. A range of different approaches are being used to implement the therapeutic switches. These include work undertaken by GP Practices and primary care prescribing support pharmacists (PSPs) and GPs using ScriptSwitch® and other decision support software.

6. Prescribing Indicators (PIs) are used to establish 'norms' for prescribing practice and as an instrument to promote consistency of prescribing practice within a number of prescribing improvement schemes. These often have a focus on reducing variation across a Community Health (and Care) Partnership, a Board or - in the case of the National Therapeutic Indicators (NTIs) - across NHSScotland.

7. Schemes based on the use of PIs were generally considered to be successful in securing significant cost improvements.

8. All Boards saw effective engagement with GP Practices as having fundamental importance in setting up and operating successful prescribing improvement schemes. All Boards emphasised the importance of good working relationships between Board PSPs and GP Practices.

9. There is considerable variation in the level of PSPs employed by different Boards to support the implementation of prescribing improvement schemes within GP Practices. This is a function of the approach taken locally to prescribing management within each Board, in particular, the level of engagement and involvement with GP Practices. This was also highlighted in the Audit Scotland *Prescribing in general practice in Scotland* (2013).

10. There was a range of different approaches taken by Boards in determining what represented an appropriate level of financial incentive for GP Practices to secure participation in prescribing improvement schemes. This was almost certainly a function of local culture and historical approach. The principle of making some payment in return for work undertaken by GP Practices was almost universally accepted.

11. All Boards make use of the GMS contract to recompense GP Practices for work carried out on prescribing improvement schemes. Some Boards grounded their schemes almost entirely within the context of the GMS contract while other Boards, in particular those whose use of prescribing improvement schemes predated the GMS contract, made more limited use of it. A number of Boards used Local Enhanced Service (LES) mechanisms to recompense GP Practices for work undertaken while others operated alternative payment mechanisms independent of the GP contract.

Review of Specific Schemes

6. Formulary Compliance

Most Boards, including all those interviewed, operated schemes which were either explicitly or implicitly through the use of PIs or designated therapeutic switches, based on formulary compliance. Typically, these were developed following a process in which primary care support pharmacists worked with GP Practices to select a range of indicators which would be used to establish targets to improve prescribing practice.

Some examples of Boards operating schemes explicitly based on formulary compliance are provided below.

NHS Lothian has in place a General Practice Intervention Project (GPIP), which is explicitly linked to its drug formulary and which has now operated since 2006. The objective of this particular scheme is to promote use of first and second line choices within the Lothian Joint Formulary (LJF) and to promote generic prescribing and dose optimisation, based on an annually agreed list of specific switches. Switches can be implemented either by GP Practice staff or by members of the Prescribing Support Pharmacy Team (PSPT), with GP Practices reimbursed only where switches are implemented by GP Practice staff. A project pack is provided and issued to GP Practices at the beginning of quarter one, with the expectation that work is undertaken and completed within a three month period to maximise the in-year benefit. NHS Lothian operates GPIP as a 'gateway' scheme, with participation of GP Practices a precondition for participation in a second tier PIs scheme. NHS Lothian reports that GPIP contributed an annual cash releasing saving in excess of £600,000 in 2012-13 with associated one off investment costs of £60,000, a return on investment (ROI) of 10 to 1.

NHS Ayrshire and Arran operated a 'Medicines of Choice' scheme until 2011-2012 with the explicit objective of maintaining and increasing formulary compliance while discouraging the use of non-SMC recommended drugs. The primary focus of this particular scheme was to improve the quality of prescribing practice and contain cost growth through promoting more consistent prescribing practice via increased formulary compliance in nine specific therapeutic areas. NHS Ayrshire and Arran estimate that this scheme has succeeded in preventing an annual cost growth of approximately £300,000 with associated investment costs of £63,000, an ROI of 4.8 to 1.

NHS Dumfries and Galloway also operated a prescribing cost improvement scheme, explicitly based on formulary compliance. NHS Dumfries and Galloway's approach was based on the use of PIs, with targets set for specific therapeutic groups, e.g. 90 per cent of lipid lowering drugs to be as per local formulary, with payment linked to the achievement of targets. This scheme is similar to that used by a number of Boards to achieve cost improvements through the use of PIs in recent years. NHS Dumfries and Galloway report annual cost savings of £270,000 in 2011-12 related to this particular scheme with associated investment costs of £76,000, an ROI of 3.6 to 1.

NHS Tayside has also operated a medicines leadership improvement programme with a key aim of reducing waste, harm and variation in the use of medicines across acute and primary care. Within this programme there was a cost improvement scheme, whose primary objective was to improve formulary compliance and thereby release cost savings. NHS Tayside's approach was to agree a set number of therapeutic switches which included eight simple formulation changes and seven more complex change initiatives for 2010-11. These were then designated as a compulsory element of a medicines management LES. The bulk of the simple changes were carried out by primary care locality pharmacists, with GPs and pharmacists in

partnership undertaking the more complex reviews. ScriptSwitch® messaging was used as a prescribing decision support tool. Reported annual cost savings were £1.85 million, and LES payments made to GP Practices totalled £114,000, an ROI of 16.2 to 1.

It is interesting to note the different approaches which were taken by each of the Boards in the schemes described above to improve formulary compliance. **NHS Lothian** and **NHS Tayside** appeared to implement two broadly similar schemes, however clearly took two very different approaches to implementation. NHS Lothian's approach appeared to be highly devolved, with maximum involvement of GP Practices and minimal involvement of central pharmacist resource. In comparison, the approach taken by NHS Tayside was a partnership approach endorsed by Tayside Local Medical Committee (LMC), with the locality pharmacists working with the GP Practices to complete the scheme. This allowed a sharing of the significant workload between locality pharmacists and GPs. NHS Lothian used a local payment mechanism while NHS Tayside's payment mechanism was through the GP contract.

NHS Ayrshire and Arran's approach was focused on containing the cost growth of non-SMC approved drugs and formulary compliance while **NHS Dumfries and Galloway's** approach was focused on achieving low cost, effective treatments.

It was apparent that cost improvement schemes based on **formulary compliance** can:

- be used effectively to improve both the quality of prescribing practice and cost efficiency
- be used flexibly to accommodate a variety of approaches as befits the culture of the implementing Board

7. Use of Prescribing Indicators

Almost all Boards operated prescribing quality improvement and prescribing cost improvement schemes based on the use of PIs. These focused predominantly on cost improvement while some of the indicators were used to focus on improving the quality and safety of prescribing practice (e.g. prescribing of antibiotics). During the development of PIs patient safety is a specific consideration.

As already highlighted, **NHS Lothian** operates a PI scheme as a second tier scheme to its GPIP. It has done so for several years based on its own historical analysis of prescribing expenditure which indicates that high PI attainment is associated with lower prescribing spend for each PI achieved. In addition a previous survey of Lothian GP Practices has confirmed that over 67 per cent place a high value on the attainment of PIs. This provides fertile ground for the continued successful operation of a scheme based on PIs.

NHS Lothian's scheme for 2012-13 is based on the use of 14 agreed indicators. These include a mix of quality and cost improvement indicators. Indicators are reviewed annually by NHS Lothian's Prescribing Indicators Specialist Interest Group (PISIG) with a final list for the year ahead approved by the Board's General Practice Prescribing Committee (GPPC). Each indicator has a single target which is the same for all GP Practices. The Medicines Management Team (MMT) provided monitoring reports on a regular basis. However, the work is largely devolved and carried out by GP Practices, with support of the primary care pharmacists.

Work related to PI attainment is excluded from agreed MED 6/10 GP contract related actions to avoid the potential for double payment and work undertaken by GP Practices is paid from an incentive fund set up for this purpose. An average sized GP Practice which met the 14 PIs can expect to receive between £2,000 and £3,000 from the incentive fund. NHS Lothian believes that payment for work undertaken, together with recognition of historical achievement by GP Practices, have been key factors contributing to the success of this scheme. The Lothian GPPC have previously reported that high PI attainment is associated with lower prescribing spend. In 2011-12 that equated a 1.6% drop in prescribing spend within those areas targeted by PIs.

NHS Greater Glasgow and Clyde (NHS GGC) also operated a PI scheme, described as a 'rational prescribing scheme' in 2011-12. This scheme presented GP Practices with a menu of 60 different indicators focused on prescribing quality and cost improvement. NHS GGC`s approach was to allow each GP Practice to select those three indicators where potentially the greatest quality improvement and/or cost improvement could be secured. Typically these were indicators where a GP Practice was identified as an outlier in terms of its current position. Indicators were selected by individual GP Practices based on the advice of its GP Prescribing Lead and its designated PSP. Each GP Practice had its own custom built target for each indicator representing a measure of progression by the GP Practice through the inter-quartile range for the indicator. NHS GGC views the timely provision and effective use of monitoring data, and effective engagement between GP Practice prescribing leads and designated PSPs as key to the successful operation of this particular scheme. Payment rates were set taking cognisance of payments made to GP Practices for work done associated with MED 6/10 GP contract related actions. A separate list of three indicators was selected for MED 6/10 GP contract related actions as part of the process described above. NHS GGC, although unable to attribute cost savings to specific schemes, estimated that the level of annual cost improvement related to schemes based on the use of PIs alone was approximately £6.4 million. The annual cost of operating the scheme in addition to the prescribing support team resource was approximately £650,000.

It is interesting to contrast the different approaches used by NHS Lothian and NHS GGC. NHS Lothian's approach is highly devolved in nature with a high level of involvement of GP Practices whereas NHS GGC's is less devolved with a higher level of involvement of Board pharmacist resource. This is reflected in a higher level of primary care pharmacist support resource employed within NHS GGC compared to NHS Lothian. The explanation for this is almost certainly cultural. NHS Lothian has taken a consistent approach to prescribing management over a number of years. GP engagement, and leadership within the Medicines Governance Teams have driven forward the culture that existed before the 1990s, such as the leadership around introduction of the LJF.

NHS GGC was later in embarking on its own programme of active prescribing management deploying a greater level of primary care pharmacist resource through 'invest to save' initiatives. One reason that the culture in NHS GGC was different to NHS Lothian at that time was that the GP community was less interested in cost containment and more engaged with new advances in patient care with early adoption of newer medicines. Notwithstanding this difference in approach, the primary objective of both Boards in operating PI based schemes was prescribing quality and cost improvement. More recently NHS Lothian invested in a polypharmacy project which led to the primary care pharmacy team employing additional staff on an 'invest to save' basis and offering additional payments to GPs under a service level agreement.

Both Boards reported significant cost improvements as a result of operating such schemes.

Other Boards including NHS Tayside, NHS Grampian and NHS Ayrshire and Arran all operated schemes based on the use of PIs. NHS Tayside's scheme offered GP Practices a menu of ten indicators from which each GP Practice was able to select three. The indicators available for selection included a spread of indicators related to patient safety, quality and cost effectiveness. The actual range of indicators selected reflected this spread of objectives and the financial outcome reported, which indicated that the cost of operating the scheme was covered by the level of cost saving achieved, reflected the approach taken.

NHS Grampian operated a PI scheme with the general objective of improving its overall prescribing practice. It did not regard financial recompense for work undertaken as necessary, choosing instead to rely on the provision of timely and appropriate monitoring data to GP Practices, the provision of education and training and effective engagement between GP Practices and PSPs as the route to securing improvements in prescribing practice. Information on costs and cost improvement was not available.

NHS Ayrshire and Arran operated two PI based cost improvement schemes during 2011-12, both firmly connected to the GP contract. In embarking on the implementation of schemes of this nature, NHS Ayrshire and Arran was seeking to ensure that they followed an approach which resonated with its local GP community. Considerable care was taken with the design and implementation of the process of engagement with GP Practices and also with the design and development of support packs where therapeutic switching might be required. Annual costs were reported as being approximately £280,000 with annual cost savings of approximately £1.25 million, an ROI of 4.5 to 1.

It was clear from the above that the use of PI based schemes can have a significant impact on prescribing expenditure and in securing cost improvements. It was also clear that in terms of approach, one size most definitely does not fit all and individual Boards require to identify and deploy an approach which fits best

with local circumstances, finance and culture. The culture and historical approach support prescribing success, the availability of additional resources contribute to the approach taken.

In addition, different Boards may have to address different priorities at different points in time, dependent upon their current position, be these quality improvement, improved cost effectiveness and/or patient safety improvement. These priorities will inevitably influence local scheme design and development.

Finally, it was clear that those Boards who established clear priorities and set clear primary objectives for their schemes put themselves in the best position to achieve their targeted outcomes. Strong leadership at Board level and a clear focus on this agenda were important factors in delivery of outcomes.

8. Specific Drugs

A number of Boards provided examples of schemes which were based on addressing the prescribing of a single drug. For example, **NHS Forth Valley** and **NHS Highland** operated schemes to reduce inappropriate prescribing of ezetimibe and ensure consistent prescribing in line with local formulary/guidance. **NHS Fife** operated a scheme aimed at switching rosuvastatin to atorvastatin for broadly the same reasons, recognising that local prescribing had moved out of line with that across NHSScotland. All three Boards reported substantial cost reductions relative to modest investments in resource, indicating that a highly focused approach can be very effective in addressing a specific issue. **NHS Dumfries and Galloway** provided an example of a scheme where they had sought to promote the use of the lowest cost gonadorelin analogue in new patients during 2009-10. They reported that the outcome of doing this was an annual cost reduction of £80,000 with costs incurred of £19,500, again illustrating the value of a highly focused approach.

9. High Risk Medicines and Patient Safety

NHS Grampian provided an example of a scheme where, under the umbrella of a LES, they had sought to strengthen their system for monitoring the use of a list of high risk medicines. This illustrated that prescribing improvement schemes need not always be focused on cost improvement but can also be used to improve safety and quality of prescribing practice. Cost avoidance may also be a by-product of such a scheme.

In recent years a number of Boards have implemented schemes promoting a more focused approach to the prescribing of specific drugs such as antibiotics. **NHS Forth Valley** provided an example of such a scheme aimed at reviewing and improving the prescribing of quinolones antibiotics.

10. Therapeutic Substitution

Therapeutic switches are an integral part of many prescribing cost improvement schemes. Most Boards until recently have implemented switches manually, in tandem with medication reviews, either through GP Practice staff or through PSPs, or sometimes through a combination of both, depending on the commitment or capacity of individual GP Practices to carry out the work required. Sustaining switches which have already been made, or making new switches as a result of changing drug prices, in order to maintain prescribing cost effectiveness can be challenging and time consuming due to the on-going manual effort required. In addition, ensuring a consistent approach across all GP Practices in terms of prescribing and therapeutic substitution can also be challenging in terms of the resources required.

Due to the change in GP Practice clinical systems in recent years, a prescribing decision support software tool, ScriptSwitch®, has become available. This can now be operated in conjunction with both GP Practice IT systems used in Scotland, INPS-Vision and EMIS, and is capable of supporting and enabling therapeutic switching to be carried out in line with local formularies. ScriptSwitch® is a point of prescribing electronic support tool which uses a messaging facility to influence prescribing decisions made by GPs. It can be used both to impart quality, safety and medicine availability related messages, and to identify cost effective choices based on local drugs formularies.

NHS Highland, NHS Grampian and NHS Tayside have all been using ScriptSwitch® since 2010 and provided examples of schemes which had been implemented with ScriptSwitch® as a prescribing support tool. The

primary focus of these schemes is cost improvement. Each Board attributed significant annual cost improvements associated with the use of this particular tool:

NHS Board	Annual Cost Saving (£)	Annual Cost (£)	Return on Investment
NHS Highland	**270,000**	**120,000**	**2.6 to 1**
NHS Grampian	**780,000**	**210,000**	**3.7 to 1**
NHS Tayside	**280,000**	**150,000**	**1.9 to 1**

ScriptSwitch® is in essence a prescribing decision support tool which seeks to effect a sustained change in prescribing behaviour in terms of consistently improved formulary compliance. As a result each Board highlighted the difficulty in calculating a precise value for on-going annual cost savings where changed prescribing practice had actually become embedded. In addition, because each Board was seeking to use ScriptSwitch® to address its own local priorities, caution is required in drawing any conclusions from a comparison of the financial figures reported in the table above. What can be concluded from a review of the financial figures reported is that the use of ScriptSwitch® can lead to potentially substantial cost improvement . However, ScriptSwitch® is not a low cost option. An unquantifiable element is the value added benefit of those changes that have been actioned by a trigger message, which are then continued and integrated into daily prescribing practice and therefore not measurable by the tool in future.

Each Board confirmed that considerable careful planning was required to successfully implement ScriptSwitch®. It appeared that in each Board, implementation had taken place over approximately two to three years. **NHS Grampian and NHS Tayside**, during the course of their follow up interviews, both emphasised the importance of effective engagement with GP Practices in developing and taking forward implementation plans. **NHS Grampian** highlighted the importance of thinking through the selection of switches to establish an appropriate mix which would be supported by GP Practices. **NHS Grampian and NHS Tayside both** highlighted the crucial importance of managing the volume and type of messages presented to GPs by ScriptSwitch® on an on-going basis, to avoid overload and ensure that it continued to have credibility with GPs as an effective support tool. This required a modest level of input from central pharmacy resource on an on-going basis. In addition, **NHS Grampian** stressed the importance of good working relationships between GPs and PSPs in terms of on-going reviews and monitoring of GP Practice responses to offer messages, and acceptance ratios. **NHS Tayside** noted that the messaging took some time to develop successfully and highlighted the value of establishing a user group, comprising both supporters and cynics, to assist with this process and develop learning.

NHS Tayside indicated that the value attached to the use of ScriptSwitch® may be limited to a fixed period of time, as a support tool to encourage and embed behavioural change in terms of prescribing practice.

In conclusion, it appeared that those Boards who had implemented ScriptSwitch® had found it to be beneficial in influencing prescribing behaviour, and possibly as a catalyst for reflecting on prescribing practice across a Board. Where this culture already exists, careful consideration should be given to the use of such a tool in terms of potential added value.

11. Other

It is possible to use prescribing improvement/incentive schemes to seek to effect changes in prescribing behaviour in a wide range of areas, including some not already identified above. **NHS Highland** provided an example of a scheme which they are seeking to take forward under the umbrella of a Polypharmacy LES, focused on medication reviews of frail elderly patients, and which may produce improvements in both quality and cost effectiveness. **NHS GGC** also provided an example of a scheme, under the umbrella of a LES, focused on GP Practices carrying out a defined list of tasks including medication reviews and reviews of repeat prescriptions aimed at identifying and reducing the level of prescribing waste. It will be valuable to review the outcomes of these particular schemes when they become available and consider the potential for wider use within other Boards.

12. Conclusions

The review attempts to provide an overview of the range of prescribing improvement/incentive schemes currently being used within NHSScotland. It highlights that the driver for prescribing initiatives is to improve safety, quality and cost effectiveness of prescribing. These drivers are consistent with the NHS Scotland Quality Strategy (2010) and the new Prescription for Excellence vision and action plan (2014). Through the summary of key points and the examples of specific schemes which have been described, it seeks to provide information which Boards could find useful and provide some learning which will assist the on-going development of future plans.

As a summary report, it is unable to include details of every scheme currently operated by each Board. However, in order to provide a greater level of detail to practitioners, the Scottish Prescribing Advisers Association (SPAA) is launching a website where Boards will be able to store and access information and resources on prescribing improvement/incentive schemes operated within NHSScotland. It is planned to have this facility in place in early 2015.

The overarching conclusions which can be drawn from this review are summarised below as:

1. Schemes which are grounded on local **formulary compliance**, with or without a linkage to PIs, would appear to be most durable, and most likely to achieve quality, safety and cost improvement which is sustainable over time.

2. A **strategic approach** should be followed, creating a series of schemes which are complementary in terms of objectives, but joined up where appropriate to guard against duplication or overlap. This is more likely to produce a successful outcome than a series of individual initiatives. It follows that it is important to have strong leadership clearly focused on both the short and long term strategies for this topic in each Board.

3. **'One size does not fit all'.** Culture is a key factor, and Boards must take care to ensure that what they attempt to do, while always striving to improve local prescribing practice, fits with their local culture and engages meaningfully with their prescribing communities. This means that different approaches are likely to be required to achieve the same targeted outcomes in different Boards. This includes the necessity to consider investment of sufficient management resources to achieve intended objectives.