FOCUS ON…….. EXCESSIVE PRESCRIBING

Annex 8 of the Revisions to the GMS Contract 2006-07 'Excessive or inappropriate prescribing: guidance for health professionals on prescribing NHS medicines' is a document aimed at helping LMCs and PCOs encourage appropriate and cost-effective prescribing.

Within the GMS and PMS Regulations and APMS Directions there are clauses in relation to Prescribing and Dispensing[1]:

Excessive prescribing

(1) The contractor shall not prescribe drugs, medicines or appliances whose cost or quantity, in relation to any patient is, by reason of the character of the drug, medicine or appliance in question in excess of that which was reasonably necessary for the proper treatment of that patient.

(2) In considering whether a contractor has breached its obligations under sub-paragraph (1) the Primary Care Trust shall seek the views of the Local Medical Committee (if any) for its area.

We are aware of cases where PCOs and LMCs seem to be taking a different view on what is excessive prescribing, and in some cases PCOs are making financial threats to practices. We have detailed below suggestions on how best to understand issues around excessive prescribing in practice, and what is or is not possible within the regulations.

Appropriate and cost effective prescribing

Cost-effective prescribing is a dynamic situation and the choice of the most cost-effective drugs changes with time.

GPs have historically been involved in measures to ensure appropriate and cost-effective prescribing, not least through prescribing incentive schemes, and there is provision in the QOF for rewarding good medicines management. Prescribing budgets make up a very significant amount of PCO spend in primary care and in an NHS with finite resources the GPC recognises that every decision made by a doctor, whether prescribing or referral, has resource implications and GPC supports best practice in prescribing which includes consideration of cost effectiveness.

Some PCOs, in an effort to cut costs, are providing a list of drugs they wish to stop providing within their PCO area. They are, in essence, advising GPs that they should no longer prescribe them. We have had queries regarding whether GPs could be in breach of their contract should they fail to provide such a drug for a patient and if indeed PCOs can exact a financial penalty for prescribing such items.

We would make the following comments in relation to such lists:

1. The only drugs which a GP may not prescribe under the NHS are those on the "Black" or "Grey" lists.

2. A practice is required, under all types of contract, to prescribe any drugs, medicines or appliances which are needed for the treatment of any patient.

[1] GMS Contracts Regulations Schedule 6 Part 3 paragraph 46
PMS Agreements Regulations Schedule 5 Part 3 paragraph 44
Scottish 17C Regulations Schedule 1 part 3 paragraph 14
Scottish GMS Regulations Schedule 5 part 3 paragraph 43
NI GMS Regulations Schedule 5 part 3, paragraph 43
GMS Wales Regulations Schedule 6 part 3 para 46
APMS (No 2) Directions 2005 Para 5(1)(e)

3. National guidelines and advice should be followed where available [LMC Conference Policy 1995:21]

4. A PCO cannot impose a local "black list". A PCO and LMC may draw up local prescribing guidelines, but such guidelines should be evidence based and flexible to allow the needs of individual patients to be met. There may, indeed, be some medicines that GPs would consider it reasonable to restrict. For instance, we are aware of one example where, amongst other drugs, expensive topical NSAIDS have been restricted where there are cheaper versions available.

5. If the LMC agrees to such a local policy with the PCO (and the financial situation of PCOs may mean that many LMCs are forced into discussing this issue) this will clearly affect some patients and GPs will want to ensure that those patients understand where the desire to restrict is coming from. The LMC should ensure that all practices that will be affected by a local prescribing policy receive from the PCO details of the preparations and drugs they should not normally prescribe; PCOs should make available the evidence base used in drawing up local guidance.

6. The LMC must insist that any such guidance can only be advisory and that GPs must remain free to prescribe any drug on the drug tariff if they believe it appropriate. Practitioners prescribing outside local or national guidelines should be advised to keep contemporaneous medical records detailing the reasons for the prescription. If it is outside of the guidance, they may have to justify their decision with reasons and it will be for the PCO to decide, in consultation with the LMC, whether para 46 has been contravened. GPs must also be mindful of the views of the GMC and medical defence organisations that patients must never have appropriate and necessary treatment withdrawn for financial reasons alone.

7. GPs are always free to prescribe as they believe and can justify are clinically appropriate. There is no regulation stopping them from prescribing any drug not on the Black or Grey lists.

8. PCOs may threaten practices with the withholding of funds or non-payment in relation to prescribing. This is not possible. Prescribing as a clinical activity does not receive specific remuneration and therefore money cannot be withheld in relation to it. There is no regulation that allows this behaviour and any PCO threatening to withhold funding should be asked to indicate the regulation they imagine does permit it. A PCO could only take action against a practice if they could demonstrate, to the satisfaction of the LMC, that the practice had contravened para 46, and thereby breached their contract.

9. Breaches of contract, with the exception of paragraph 114 actions (i.e. patients are at danger if the contract is not terminated), are rarely the result of single events but usually progressive. All breaches of contract are subject to dispute resolution in the Family Health Services Appeal Unit (FHSAU) or the courts. Financial sanctions are also subject to dispute resolution and the courts. It is unlikely that a practice's statin prescribing is justification for breach of contract.

10. Statements by PCOs indemnifying individual practices against future action by patients who believe that they have been damaged by refusal-to-treat decisions have no legal force and do not provide any protection at all.

Drug switches

There is unlikely to be any practice that hasn't experienced a PCO instruction to change all patients on X statin to Y statin because it will save the PCO a said amount of money. This form of wholesale drug switching is both an inconvenience and interference that practices would not normally choose. The change may be clinically appropriate and in certain cases it may be financially appropriate (i.e. if there are significant savings to be made as opposed to simply switching from month to month to save a few pennies here or there). Where it is reasonable to switch a patient then practices may agree to do so. However GPs must always use their clinical judgement and, where they can make a clinical case for not switching a patient, they have every right to continue to prescribe as they feel is clinically appropriate. GPs continue to carry responsibility for their prescribing decisions. GPs are responsible for anything they sign and, even if they feel they are being coerced to change by the PCO, they should only change prescribing if they believe it to be correct for an individual patient.

Practices should also be able to decide on the most appropriate method of switching, e.g. bulk switching, where a whole of a practice's relevant population are switched to the new drug en masse, or switching at routine review. Where a bulk switch is made at the request of the PCT they should provide adequate resource to facilitate the switch including the input of the PCT pharmacy advisor and resources to inform patients of the change.

General points for LMCs to consider when negotiating with PCTs

PCOs spend money that can go into GP practices and primary care services. They should be made aware that prescribing needs to be fully funded and where there are cost savings they should normally be reinvested in primary care.

Many patients are oblivious to the cost of their drugs. Some would argue that those who are aware rarely object to changing to a lower cost drug of equivalent clinical effectiveness knowing that the savings can be reinvested in services for patients.

Most GPs would accept that high prescribing costs only reduce the total money available for other services. Managing prescribing in a cost-effective way need not necessarily affect the quality of clinical care.

There should never be any question of rewarding anyone for withholding treatment.

Newer drugs are constantly being developed and it is important that patients should benefit from improvements in medical care. Prescribing decisions should be made, first and foremost, on the basis of good clinical care.

Where there are GPs in the LMC area who have prescribing patterns of a historic basis that appear to be significantly out of step with other colleagues and which cannot be explained by demographic or other arguments, the LMC will want to encourage the PCO to work with the practice, and provide the relevant educational input, to enable progress towards more efficient prescribing.