Focus on excessive prescribing

Updated February 2018

This guide aims to provide background support to Annex 8 of the revisions to the GMS Contract 2006-07 'Excessive or inappropriate prescribing: guidance for health professionals on prescribing NHS medicines' to support LMCs in their work with Primary Care Organisations (PCOs) on prescribing matters. [Note that we will refer to PCOs throughout the guidance, which covers Clinical Commissioning Groups in England, Health Boards in Scotland, Local Health Boards in Wales and Health and Social Care Boards in Northern Ireland].

"Excessive prescribing" is defined within contractual regulations for GPs[1]. Practices can be in breach of their contract by prescribing drugs, medicine or appliance 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 is reasonably necessary for the proper treatment of that patient[1]. PCOs are authorised to manage excessive prescribing and any health professional believed to be prescribing excessively may be subject to challenge by their PCO and required to justify their prescribing behaviour.

We are aware of cases where PCOs and LMCs seem to have taken a different view on what constitutes excessive prescribing, and in some cases PCOs have made financial threats to practices. We have detailed 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 Quality and Outcomes Framework for rewarding good medicines management.

Prescribing budgets make up a very significant amount of expenditure 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, provide 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 continue to prescribe such a drug for a patient and if indeed PCOs could exact a financial penalty for prescribing such items.

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[1] GMS Contracts Regulations 2004 Schedule 6, Part 3, paragraph 46
PMS Agreements Regulations Schedule 5 Part 3, paragraph 44
Scottish GMS Regulations Schedule 5, part 3 paragraph 43
Scottish 17C Regulations Schedule 1, part 3, paragraph 14
Northern Ireland GMS Regulations Schedule 5, part 3, paragraph 43
GMS Wales Regulations Schedule 6, part 3, paragraph 46
APMS Wales Directions 2008

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.

3. National guidelines and advice should be considered where available.

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 461 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 461, 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.

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.

Shorter duration prescribing

There have also been requests for GPs to consider shorter duration prescribing (i.e. 28 day prescriptions). Prescribing intervals should be in line with the medically appropriate needs of the patient, taking into account the need to safeguard NHS resources, patient convenience, and the dangers of excess drugs in the home. They can also place significant and unnecessary workload on the doctor and surgery staff. Pharmacy requests to issue 7 day prescriptions for ease of administration into medication dosing aids are not contractually required and to be discouraged. A report[2] on prescribing durations recognises that shorter prescriptions are associated with significant increases in dispensing and other transaction costs, together with reductions in compliance in previously stable patients, and an increase in dissatisfaction amongst patients because of travel costs and time to obtain regular medicines.

Drug switches

Many practices will probably have experienced an instruction to change all patients on drug X to drug Y because it would have saved 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 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 PCO they should provide adequate resource to facilitate the switch including the input of the PCO pharmacy advisor and resources to inform patients of the change.

Computer software integrated into the clinical system may suggest alternative, more cost-effective options for prescribing for an individual patient. Where clinically appropriate, GPs should try to be mindful of prescribing costs but there is no contractual obligation for clinicians to adhere to all such software suggestions.

[2] Individualisation or standardisation: trends in National Health Service prescription durations in England 1998–2009, http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8704510

General points for LMCs to consider when negotiating with PCOs

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.

Where there is no clinical indication to prescribe a more expensive drug or formulation, GPs should prescribe cost effectively. Sometimes this means explaining to patients that while their personal preference may be for one drug preparation over another, if there is no clinical need this is not an effective use of NHS resources.

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.