

Revisions to the GMS contract 2006/07 - Annex 8 Excessive or inappropriate prescribing guidance

Introduction:

The term 'excessive prescribing' has been included in the GMS contract for some time. However, differences of opinion of its interpretation have limited the use of this particular element of GPs obligations as contracted providers to the NHS.

Significant changes in prescribing patterns by a minority of dispensing practices across England, in attempts to offset dispensing profit reductions caused 'Category M' generic drugs in 2005, prompted the DoH negotiators to seek agreement on guidance with the GPC and Dispensing Doctors Association representatives, to support the interpretation of 'excessive prescribing' as part of the negotiations of the revisions to the GMS contract for 06/07.

(Drug Tariff Category M generic price reductions, introduced nationally in April 2005, represent a planned national policy to bring the price that the NHS pays for drugs, closer to the actual price that pharmacies and dispensing doctors purchase the drugs for, at the expense of reducing the dispensing profits margins involved.)

Annex 8 of the revised nGMS contract 06/07 states that:

Principles:

'NHS cash for prescribing is part of the wider resource available for the care of patients.'

'Professional guidance on standards of practice states that it is the responsibility of every prescriber to make efficient uses of the resources available (e.g. GMC Good Medical Practice). The GMC advises doctors that they have a responsibility to consider the impact of their actions, such as prescribing, on resources available to other patients As a guiding principle it is appropriate to prescribe the most cost effective medication for a patient'

"Excessive prescribing" is defined within contractual regulations for GPs. GP 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"* (NHS General Medical Services Contracts Regulations 2004, Schedule 6, Part 6, Paragraph 46).

'The PCO will need to consider whether there is sufficient evidence to demonstrate that the contractor's prescribing practice constitutes a breach of their contractual requirement'

'If there has been a breach of contract then the PCO will need to consider issuing a breach or remedial notice or invoking a contract sanction. If the contractor does not accept that they have breached their contract or that the PCO's action is appropriate it can challenge the PCO action by invoking the dispute resolution mechanism. The LMC may be involved as appropriate'

Examples that may be judged to indicate excessive prescribing

The following examples, taken from the revised GMS 06-07 guidance, illustrate behaviours that may be judged to indicate excessive or inappropriate prescribing, particularly where this has been done for a significant proportion of patients and/or in a systematic manner by health professionals or their staff:

- 1) Prescriptions where the drug is initiated or switched, e.g. within a therapeutic class/indication, with the effect that reimbursement is based on a product that provides a larger purchase margin for the prescriber(s) and the product(s) selected cost the NHS more, unless there is good clinical evidence to support the switch
- 2) Prescribing that is varied according to the impact on reimbursement to the practice, e.g. differences between patients to whom the practice directly supplies medicines (including personally administered drugs and through NHS dispensing) and those to whom they supply prescriptions for dispensing elsewhere, and where the prescriber(s) is/are unable to provide a reasonable explanation
- 3) Profligate prescribing may be considered to exist where the prescriber(s) consistently prescribes excessive amounts of high cost products or inappropriate, high quantities of medicines that are significantly at variance with comparable clinical scenarios and where the prescriber(s) is/are unable to provide a reasonable explanation

The below details represent two practice scenarios that currently exist in Gloucestershire.

Senario 1: A dispensing practice that was prescribing simvastatin as their first choice statin, and reached prescribing levels of almost 80% of all statins prescribed as Simvastatin during the majority of 2005. At the end of 2005, prompted by Category M dispensing profit reductions, the practice decided to switch to a more expensive patented statin that offers a higher level of dispensing profit (eg. atorvastatin) and within a period of 2 months switched the majority of its dispensing patients (approx half of practice list) from Simvastatin to atorvastatin. The resultant additional cost impact on the PCT's drug budget is approximately £50K pa.

The PCT considers this to be 'excessive prescribing' and therefore, unless the practice agree an action plan with the PCT to reverse this prescribing change (dialogue with the practice has not to date resulted in such an agreed action plan) it constitutes a breach of the terms of the GMS contract.

Senario 2: A dispensing practice refuses to accept the NHS (PCT & NICE) cost effectiveness recommendation, accepted by almost all other local practices, to prescribe Simvastatin, as the first choice, most cost effective statin, for the majority of patients. The practice refuses to try changing any patients currently on more expensive patented statins onto simvastatin. Instead, the practice continue to

prescribe fluvastatin as their first choice statin, but is prepared to switch their atorvastatin patients to rosuvastatin (which may offer the practice higher levels of dispensing profits). Because of the significant cost difference of Simvastatin to patented statins, the practice's statin prescribing is costing the PCT £30K pa more than if the practice had changed to the high levels of Simvastatin prescribing that the majority of other practices in the PCT have achieved.

This practice is also a high prescriber of pantoprazole as first choice PPI. This is costing the PCT £20k pa more than the average practice's PPI prescribing, which incorporates significantly higher levels of generic omeprazole. The practice in question refuses to prescribe omeprazole as its first choice statin, however is prepared to switch current pantoprazole patients to lansoprazole (which currently offers higher dispensing profits).

The PCT considers this practice's statin and PPI prescribing to be 'excessive prescribing' and therefore, unless the practice agree an action plan with the PCT to reverse these prescribing patterns (not agreed from dialogue with practice to date) it constitutes a breach of the terms of the GMS contract.

1. Comments from the LMC on the PCT interpretation of 'excessive prescribing' within the GMS contract, in both the above two scenarios, are welcome.

Practice Register of Gifts & Hospitality:

The 06/07 nGMS guidance on excessive prescribing also states that:

Substantial sponsorship or financial deals that could reasonably be perceived to affect the choice of treatment in a way that is financially beneficial to the prescriber but significantly increases NHS costs, other than where there is clear evidence of clinical benefit to patients, should be recorded in a register of "Gifts and Hospitality".

An obligation to keep Gifts & Hospitality Registers are well established in all public organizations. The PCT regards any pharmaceutical sponsorship of a value of greater than £25 as 'substantial' and therefore should be recorded by practices in a practice register of "Gifts and Hospitality".

2. Comments are welcome from the LMC on this issue, and on the LMC recommendation to practices on this aspect of the nGMS revised guidance.

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