NHS Brighton and Hove Clinical Commissioning Group

Medicines Management Guideline

Managing Potentially Excessive or Inappropriate Prescribing

Where 'the CCG' is referred to in this document, this covers;

- **NHS Brighton and Hove Clinical Commissioning Group**

1. Introduction

This guidance has been produced to support best prescribing practice and is intended to inform all prescribers in relation to prescribing behaviour that could be considered excessive or inappropriate. This guidance refers to Annex 8 nGMS regulations 2006 revisions which specifically relates to GP contracts but the principles will be applied to any prescriber working for or on behalf of a practice. This guidance sets out how the CCG manages such behaviour and describes a process for escalation of issues if necessary.

2. Purpose and Scope

This is guidance drawn up by the CCG to manage potentially inappropriate prescribing. The British Medical Association (BMA) recognises that prescribing raises difficult issues and has produced guidance for health professionals "Annex 8" (http://goo.gl/g6Tiy2) which considers examples of what may be considered as excessive or inappropriate prescribing. It is the CCG's responsibility to engage with practices where this may be the case and work with practices to encourage current best practice to ensure that all prescribing is professionally appropriate in terms of quality, cost effectiveness and affordability in the context of the overall use of NHS resources.

The purpose of this document is to clarify and endorse the process of addressing identified issues occurring at any stage in the prescribing process that differ significantly from what may usually be expected. It is assumed that discussions will take place with the GP practice concerned, the CCG and, where appropriate the LMC before any action is taken. Potential excessive or inappropriate prescribing issues should be resolved in most instances without further reference to this guidance. This guidance should only be applied in those instances where local agreement cannot be reached. The guidance should be used in conjunction with the CCG Joint Formulary which includes the local "blacklist".

3. Duties and responsibilities - Contractual Requirements

In March 2006, the BMA and NHS Employers published joint guidance for health professionals on excessive or inappropriate prescribing of NHS medicines (Revision of the GMS Contract 2006 - Annex 8). The BMA recognises that by improving quality, cost effectiveness and affordability of prescribing in the context of the overall use of NHS resources would be of benefit to patients.

Although the CCG has authority for monitoring and managing excessive prescribing under GMS and PMS contractual regulations, the decision as to whether or not a GP Practice is in breach of their contract is open to interpretation and subsequent challenge. The CCG has a responsibility to ensure that it works with the LMC to employ a consistent and transparent approach when dealing with all contractors under this regulation. An agreed policy outlines clear expectations around the application of Annex 8 within the organisation and ensures that due process is followed enabling all interested parties to have a fair and reasonable opportunity to resolve prescribing disputes without the need to apply contractual sanctions.

This document supplements the national guidance by illustrating for General Practitioners (GPs), practice staff and other health care professionals (including other prescribers) the prescribing behaviours that may give rise to further enquiries about prescribing activity

It is important to note that the CCG will address both aspects of Annex 8 through this guidance. Namely in addition to potential "excessive" prescribing the CCG will also be supporting its regulatory requirement "to investigate a prescriber that consistently significantly under-prescribes where there is evidence to suggest that there is a failure to adhere to good clinical prescribing practice."

The contractual arrangements and the steps that would be taken by the CCG if it had reason to believe prescribing was potentially inappropriate or excessive are set out in this CCG guidance (see Appendix 1).

4. Context

Medicines contribute enormously to the health of the nation. The effective use of drugs have improved many people's quality of life, reduced the need for surgical intervention and the length of time spent in hospital and saved many lives (both in primary and secondary prevention). Our consumption of drugs is increasing and accounts for approximately 12% of the NHS budget. However, there are disadvantages in the increasing use of and reliance on medicines. The inappropriate or excessive use of medicines can cause distress, ill-health, hospitalisation and even death. Adverse drug reactions are responsible for about 6.5% of all admissions to hospitals in the UK[1]

Prescribing data indicates significant variability between GPs (or other primary care prescribers) and between clusters of GPs, which may indicate that over-/ under-prescribing and inappropriate prescribing may still be occurring in some areas. Professional guidance requires efficient use of the resources available and the impact on other patients to be considered. Changes in prescribing should take account of these criteria as well as clinical appropriateness and patient need at practice and CCG level.

In 2008, 843 million prescriptions were dispensed in England and 98.6% of these were prescribed by GPs. Inappropriate prescription of medicines by GPs is of particular concern. Excessive use of medicines leads to increased exposure to the risk of drug-induced illness and harm. The House of Commons Select Committee on Health, Fourth Report 2005, recommended tougher restrictions be placed on what non-specialists can prescribe and greater vigilance to guard against excessive or inappropriate prescribing.

[1] Pirmohamed M *et al*, Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients. *BMJ.* 2004; **329**: 15-19

5. What is potentially inappropriate or excessive prescribing?

The situations highlighted below illustrate prescribing behaviour that has been locally or nationally identified as likely to raise questions about inappropriate or excessive prescribing (this list is not exhaustive). Examples relating to each situation are given in Table 1:

- Prescribing for private patients returning to NHS care where this differs significantly from usual NHS care
- Prescribing of products that are not indicated for prescribing on the NHS
- Consistent / significant under-prescribing where there is evidence to suggest that there is a failure to adhere to good clinical prescribing practice
- 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
- 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
- Prescribing that is varied according to the impact on reimbursement to the practice, and where the prescriber(s) is / are unable to provide a reasonable explanation 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

6. Identification of potential excessive or inappropriate prescribing

Prescribing is monitored routinely by the CCG Medicines Management Team. The CCG will also act on complaints received directly or through NHS England.

The standards used to judge inappropriate or excessive prescribing are based on:

- Guidance issued locally, nationally and from professional bodies
- Reviewing and benchmarking prescribing for all practices in all therapeutic areas, over time, against other practices locally and nationally using ePACT data and other information; identified population needs and demographics will be taken into account

Where appropriate, the results of such monitoring will be discussed with an individual prescriber or with the practice and appropriate actions agreed.

7. Process for managing inappropriate or excessive prescribing

The process for managing inappropriate and excessive prescribing is outlined in Appendix 1.

8. Acknowledgments

With thanks to NHS High Weald Lewes Havens CCG, NHS Bedfordshire CCG and NHS Surrey CCG for sharing their policy on which some of this document is based.

Table 1. Examples of what is potentially inappropriate or excessive prescribing

DEFINITION	EXAMPLES
Prescribing for private patients returning to NHS care where this differs significantly from usual NHS care	a. Prescribing of products that would not usually be prescribed for NHS patients in primary care such as drugs that are "red" (Specialist only) on the CCG traffic light system within the Joint Formulary b. Acceptance of prescribing responsibility for medicines that should be initiated, monitored and stabilised in secondary/tertiary care earlier than would normally be expected for a patient treated within the NHS – amber (shared care) or blue medicines on the CCG traffic light system on the joint formulary c. Prescribing of products that are not in line with CCG Joint Formulary or national guidance on the basis of private patient/consultant request d. Prescribing of products that would not routinely be prescribed for NHS patients such as those included in the local blacklist, not on the Joint Formulary, or those on the national black or grey lists e. The CCG guidance on managing boundaries of NHS and privately funded healthcare
Prescribing of products that are not indicated for prescribing on the NHS	a . The prescribing of travel vaccines that are for holiday and business travel abroad where the reasons for vaccination fall outside of the Global Sum definitions for NHS eligibility b. The prescribing of antimalarials for prophylaxis c. The prescribing of products to patients who do not meet the specific clinical conditions as indicated by "SLS" and "ACBS" recommendations stipulated by the Department of Health d. Prescribing of products that would not routinely be prescribed for NHS patients such as those included in the local blacklist, not on the Joint Formulary, or those on the national black or grey lists
Consistent/significant under-prescribing where there is evidence to suggest that there is a failure to adhere to good clinical prescribing practice	a. Non-adherence to NICE guidelines or a NICE technology appraisal where patient meets eligibility criteria and where clinically appropriate
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	a. Prescribing medicines routinely where national or local guidance has recommended a limited place in therapy where standard. First line or widespread use of black triangle drugs where, within the therapeutic class, there are evidence based alternatives without black triangle status b. Prescribing routinely for periods of treatment that may lead to an increase in waste from unwanted, unnecessary or stopped medicines in situations where the clinical condition is subject to change. In particular wound management, continence & stoma products, oral nutrition supplements, palliative care, initiation of new medicines, and Controlled Drugs c. Prescribing for longer than three months for registered patients travelling overseas, or prescribing on NHS forms for patients who are not entitled to NHS treatment e.g. persons overseas. Prescribing should not exceed the amount that is usually issued and in most cases this would not usually exceed three months

DEFINITION	EXAMPLES
Prescribing that is varied according to the impact on reimbursement to the practice, and where the prescriber(s) is / are unable to provide a reasonable explanation 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.	a. Not making locally, or nationally, recommended changes in prescribing that would release money for use elsewhere in patient care where clinically appropriate for the individual patient
*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.**	a. Change from generic to brand or branded generic of the same drug or to another drug in the same therapeutic class where the alternatives chosen cost the NHS more without demonstrable clinical benefit b. Refusal, without reasonable justification, to change prescribing behaviour in line with CCG or national policy when the cost of a drug drops significantly and becomes the most cost-effective in its class c. Acceptance of associated discounts, or 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. In circumstances where there is clear evidence of clinical benefit to patients, then these discounts, sponsorship etc. should be managed and recorded in accordance with the relevant CCG policy on sponsorship/joint working and gifts/hospitality.
*This does not apply when normal trading discounts apply to the purchase of medicines. Bonus deals would NOT be considered as "normal trading discounts" for this purpose, as they may be perceived to affect the choice of treatment. This requirement applies whether or not the practice or prescriber feels that the discount, sponsorship etc. affected their prescribing. The judgment on benefit to patients could be subject to challenge against the GMC criteria relating to the balance between individual patient benefit and the use of resources to benefit other patients. If there is a change in prescribing by a practice or individual prescriber, for a significant proportion of patients or in a systematic manner to a product with a higher NHS reimbursement cost but without any clinically significant advantage to the patient, then this may be subject to challenge.	

Appendix 1: Process for managing inappropriate or excessive prescribing