PRESCRIBING IN NHS HIGHLAND

Report by Professor John Cromarty, Director of Pharmacy on behalf of Elaine Mead, Chief Operating Officer

The Board is asked to:

- **Note** and support the current structure for the governance of the prescribing and use of medicines in NHS Highland.
- **Note** the immediate and future pressures on prescribing budgets in primary care and in secondary care and consider the professional and financial resources required to meet these pressures.
- **Note** and support current initiatives to improve the cost-effectiveness of prescribing.
- **Ensure** that NHS Highland patients have equitable access to pharmaceutical care and to safe and cost-effective drug therapy.

1 Background and Summary

The August Meeting of the Highland NHS Board identified increasing prescribing costs within the CHPs. The Director of Pharmacy was asked to compile a report for the Board, to discuss the governance of prescribing, to compare NHS Highland with other Board areas and to consider future strategy.

Where comparisons can be made with other NHS Boards on the basis of full year historical data, NHS Highland appears to have performed comparatively well on prescribing costs. The prescribing patterns and the picture emerging this year within NHS Highland reflect the national situation of a projected prescribing overspend.

The contents of this paper complement presentations to be given at the Board Development Session, to be held on 30 November, 2009.

2 Prescribing in Primary and Secondary Care in NHS Highland

2.1 Governance of and Support for Prescribing

The governance of prescribing in NHS Highland is secured at professional level through the Directors of Medicine, Pharmacy and Nursing and at multidisciplinary level through the Board’s Area Drugs & Therapeutics Committee, ADTC (Chair: Dr Robert Peel), and its elaborate structure of 7 Subgroups, as follows:

- Formulary Subgroup (Chair: Okain McLennan)
- Patient Group Direction Subgroup (Chair: Helen Tissington)
- Policies, Procedures and Guidelines Subgroup (Chair: Dr Jacqueline Howes)
- Medicines Safety Subgroup (Chair: Dr Lesley-Anne Smith)
- Non-medical Prescribing Subgroup (Chair: Hilda Hope)
- Exceptional Medicines Use Subgroup (Chair: Dr Ian Bashford)
- Antimicrobials Management Team (Chair: Dr Andrew Hay)

The third edition of the Highland Formulary was published electronically earlier this year with paper copies being distributed in July. This was achieved on schedule and involved 26 Review Groups and a total of 167 individuals from all operational units. Ongoing bimonthly updates of the electronic Formulary changes are communicated to all prescribers through the distribution of the bimonthly prescribing newsletter, “The Pink One”.

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The GP prescribing systems GPASS, EMIS and VISION have all been updated with the 3rd edition of the Highland Formulary and are available for use by all GPs.

Evidence-based policies and guidance are backed on the ground by CHP Lead Pharmacists and their prescribing support pharmacist teams in the community and by clinical pharmacists in hospitals. The Medicines Information Team supports this work and also provides information on complex medication related matters for individual patients and for groups of patients.

At the present time, it should be noted that only 66% of wards at Raigmore Hospital have a regular clinical pharmacy service and most clinics at Raigmore Hospital do not have a clinical pharmacy service. There are also vacancies within Prescribing Support Pharmacist posts both in Argyll & Bute and in North Highland CHP, which remain unfilled despite repeated advertisements (AfC Band 7).

The draft process for the NHS prescribing of medicines for individual patients in NHS Highland is summarised diagrammatically in Appendix 1. This takes on board a new proposed arrangement at national level for approved “Patient Access Schemes”, which have yet to be fully implemented. This is intended to increase patient access to new expensive medicines which have not been considered by the Scottish Medicines Consortium (SMC). The intention is that this would be at no cost to the Board if the medicine proves to be ineffective for the patient.

2.2 Drugs Budgets Forecasting and Setting

The budgets for Hospital Drugs and Prescribing (in Primary care) are considered at the same time each year (late autumn and early winter) to allow for drug budget/allocation setting for the coming financial year. This work is undertaken by the Area Drugs Budget Group, comprising of senior members of staff from both primary and secondary care, from Pharmacy and from Finance.

Forecasting drug costs in a Hospital setting is dependent on understanding the timescales for the introduction of new drugs the numbers of patients likely to be treated with them. The volume of patients is far lower than Primary Care, but drug costs can be considerably higher. Horizon scanning is based on work supplied by the SMC (Look Forward), the UK Medicines Information Group and local intelligence following discussion between pharmacists and consultant medical staff. It is an inexact science as all potential new drug or new uses for existing drugs require to be identified, the outcomes of ongoing clinical trials need to be anticipated and delays in regulatory approval require to be estimated. In addition, estimates of patient numbers need to be gathered and factored in alongside expected treatment duration, as well as taking into consideration any service requirements for the new products e.g. extra pathology or radiology costs.

Primary Care prescribing expenditure forecasting is arguably more difficult and needs to account for volume (in excess of 300,000 items per month in the 3 North Highland CHPs), changes to the Drug Tariff prices, seasonal variations (e.g. holiday visitor numbers), public holiday dates (affecting the number of days in the months patient can access services), and a number of other factors. A number of models have been developed between Finance and Pharmacy in an attempt to produce accurate projections.

2.3 Managing Drugs Budgets within the NHS Highland Financial Plan

NHS Highland’s financial plan contains a basic assumption of a 6% uplift overall to both primary and secondary care drugs budgets. This may then be further adjusted in the light of the above forecasting and the actual percentage uplift has tended to be more heavily weighted towards Hospital Drugs.
This 6% uplift attempts to account for the net effect of:

- Volume increases;
- Price changes;
- New drugs;
- Drugs coming off patent;
- Any other known factors likely to change drug use e.g. national evidence-based guidelines from the Scottish Intercollegiate Guidelines Network (SIGN), the National Institute for Clinical Excellence (NICE) or other such sources.

As indicated in Section 2.2 above, the net effect of a set of complex variables is difficult to predict and the changes required to budgets have to be managed annually within the overall resource available within the Financial Plan. In the current financial year, this is proving challenging in terms of delivering a break even position both for Hospital drugs and for Primary Care Prescribing.

2.4 Drug Cost Differences between Primary and Secondary Care

Primary Care
Prescribing costs in Primary Care are incurred where GPs (and other prescribers) prescribe medicines for patients in the community. The prescriptions are dispensed by community pharmacists and dispensing doctors. The costs are charged to the NHS Board based on the reimbursement claimed by community pharmacists and dispensing doctors.

Secondary Care
Hospital medicines are ordered through Hospital Pharmacy departments and the costs are usually based on nationally, regionally or locally negotiated contracts. These drugs are either used within the hospital setting or prescribed for patients on discharge from hospital. Costs are charged directly to the ward or department concerned.

2.5 Immediate Past and Present Position of Drugs Budgets and Prescribing Spend

National Comparisons

At national level, the cost of prescriptions to the NHS in Scotland has risen from £598 million (where the average person was prescribed 11 items a year) ten years ago, to £1.07 billion in 2008-2009 (where the average person was prescribed 15 items a year). This new national total equates to £196.20 for every person registered with a GP.

In primary care locally, the average prescribing gross ingredient cost in the 3 North Highland CHPs for 2008-2009 was £189//member of the population, based on the GRO mid year estimate of the population (215,311).

At national level, total Scottish hospitals drug expenditure in 2007-2008 was 5.1% of total Scottish hospitals expenditure. The corresponding figure for NHS Highland was 3.6%. This was the lowest percentage figure of the 11 geographical Scottish Mainland Health Boards.

Combining all drug expenditure for 2007-2008, NHS Highland’s was 14.1% of its total Board expenditure for that year. Of the 11 geographical Scottish Mainland Health Boards, this was the second lowest percentage figure next to NHS Tayside’s figure of 13.9%. The highest Board percentage figure for that year was 17.8% of its total Board expenditure.

Detailed comparative NHS Board figures for 2008-2009 had not been published on the Information & Statistics Division website at the time of submitting this paper.
NHS Highland Drugs Budget Data for 2008-09 and 2009-10

Drugs budgets, previous spends and current forecast positions are shown in Table 1 below:

Table 1 – Drugs Budgets, Drugs Spends and Forecasts for 2008-09 & 2009-10

<table>
<thead>
<tr>
<th>Year</th>
<th>All Hospitals Drugs Budget</th>
<th>All Hospitals Drugs Spend</th>
<th>Primary Care ‘Drugs Budget’ (4 CHPs)</th>
<th>Primary Care ‘Drugs Spend’ (4 CHPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-2009</td>
<td>£14.087m</td>
<td>£14.036m</td>
<td>£59.120m</td>
<td>£58.877m</td>
</tr>
<tr>
<td>2009-2010</td>
<td>£15.358m</td>
<td>£15.531m(^1)</td>
<td>£58.140m</td>
<td>£58.880m(^2)</td>
</tr>
</tbody>
</table>

\(^1\) projected year end spend, based on year to date position to 30th September 2009

\(^2\) projected year end spend, based on 4 months actual prescribing data

Thus the forecast position for 2009-10 at the present time is for overspends of £173k in the hospital drugs budgets and £740k in the primary care prescribing budgets, totalling £913k overspend on the area wide drugs budget.

2.6 Prescribing in Primary Care

Pharmacy Prescribing Team Activity

Prescribing Support Pharmacists within the CHPs and Localities are responsible for the delivery of prescribing support and advice to GPs and other health care professionals in primary care. They promote safe, effective, high quality, rational, legal and cost-effective prescribing, visiting GP practices on a regular basis to provide prescribing support. Time is divided between practices according to local needs, the practice population and prescribing allocation, and in agreement with CHP and Locality priorities.

Activities of the prescribing team include:

- Promotion of evidence-based and cost-effective prescribing, in line with local and national guidelines.
- Analysis and evaluation of prescribing data in order to identify trends in prescribing and to monitor prescribing. These data are discussed with prescribers and managerial teams.
- Agreeing prescribing action points of the General Medical Services (GMS) contract with practices.
- Setting targets for changes in prescribing practice, auditing these changes and reporting the results.
- Implementation of elements of the NHS Highland pharmacy strategy within GP practices.
- Working with all prescribers to implement the Highland Formulary and in the development of protocols, policies and guidelines for prescribing.

The Pharmacy Prescribing Team is small and its effectiveness is compromised by significant and on-going staff shortages, particularly in the North Highland CHP and Argyll and Bute CHP. Despite this, all practices have prescribing reviewed on an annual basis to allow them to fulfil the Medicines Management component of QOF.

The following areas are routinely monitored and discussed with every practice:

- Non-formulary prescribing targeted savings - this is the major area for potential savings.
- Prescribing of lipid-lowering medicines in the context of NHS Highland guidelines – continuous follow-up of work to ensure most cost-effective prescribing of statins.
- Antidepressants – in support of HEAT target (T3.KPM1).
• Antibacterials – antibiotic resistance, prevention of opportunistic infections (e.g. Clostridium difficile).

Additionally in 2009-10:

• North Highland CHP has successfully piloted the use of Scripswitch, a prescribing support software package in a number of practices since the beginning of the financial year, which has resulted in significant savings. The potential benefits and practicalities of wider implementation are now being discussed in the other CHPs.
• The Pharmacy Team will support the implementation of the Chronic Pain Service (and its associated LES), the funding of which is dependent on significant prescribing savings.
• The CHP Lead Pharmacists are currently working with colleagues to ensure most cost-effective prescription and supply of stoma products, dressings and nutritional supplements.

Excessive or Inappropriate Prescribing

The GMS contract states that contractors “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.” In considering whether a contractor has breached its obligations under this clause, the Board is obliged to the views of its area medical committee.

When a member of the Prescribing Support Team identifies possible excessive or inappropriate prescribing, this is addressed in direct discussion with the prescriber or practice in an attempt to agree any appropriate remedial action. Should it not be possible to agree on a course of action, a CHP must consider whether there is sufficient evidence to demonstrate that practice breaches the prescriber’s contractual agreement. This might involve 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 CHP’s action is appropriate it can challenge the CHP action by invoking the dispute resolution mechanism. The local medical committee (LMC) may be involved as appropriate and must be involved where this is a requirement of the contract. This approach would be in line with the advice given by the British Medical Association to its members.

Pressure on Prescribing Budgets

Increases in the volume of prescribing are happening in all therapeutic areas. There are a number of possible explanations, the most obvious being that we are treating an ageing population, but, as a society we are not ageing at the rate primary care prescribing is increasing.

An increased demand for medicines on NHS prescription does not appear to be due to the reduction in prescription charges in the run-up to their eventual abolition. There has been no increase in the number of prescriptions dispensed for which the tax was levied, which might have been expected as the charge has decreased. In fact, the reverse has happened although this is balanced to some extent by an increase in items covered by pre-payment certificates. The biggest change is in items dispensed for patients aged over 60 years. This pattern seems to hold true across the country.

More detailed analysis may show some association between the advent of the financial recession and prescribing. For example, an effect might be predicted on prescribing of antidepressants and anxiolytics, and there is some evidence, at this time, of an increase in antidepressant usage. With the level of increase in prescribing for our senior citizens, we should be asking ourselves whether the increase is justified. Are we are doing more and doing it better, with resulting improved care and outcomes for patients aged over 60?

1 The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004, Part 3, Prescribing and Dispensing, paragraph 43 (Excessive prescribing)
These questions cannot be answered through examining primary care alone, but fundamental to any success will be systematic medication review for patients in primary care. There is provision for this in QOF: the Medicines Management indicators 11 and 12 specify that medication reviews should be recorded in the notes in the previous 15 months of patients being prescribed four or more repeat medicines, as well as for all patients being prescribed repeat medicines. The medication review should be at Level 2 as described by the (English) National Prescribing Centre. Regular review to this standard would go a long way to improving the quality of repeat prescribing, as would the implementation of a minimum standard for repeat prescribing in primary care. In the future, this will be complemented by the Chronic Medication Service element of the new community pharmacy contract.

2.7 Prescribing in Secondary Care

Medicines management in its broadest sense continues to be an integral part of the pharmacy service in Raigmore Hospital, in New Craigs Hospital and in the Rural General Hospitals. This includes managing the safe and effective use of medicines through policies and guidance, medicines information support and direct clinical pharmacy services, as well as aspects of medicines use redesign and cost control initiatives. Pharmacy support is also provided where possible to the community hospitals, a number of which receive clinical pharmacy services.

Existing Medicine Management can be divided into two main activities which are illustrated below from the perspective of Raigmore Hospital:

1. Safe and Effective Medicines Management Systems:
   - The Area Drug and Therapeutics Committee and its 7 sub-committees all contribute to the safe and cost effective prescribing and use of medicines by scrutinising protocols and procedures and assessing medicines safety. All of this work is led and/or professionally supported by Pharmacy staff.
   - Use of medicines recommended in the Highland Formulary (HF) wherever possible. Current formulary compliance in Raigmore Hospital is over 95%. Most non-formulary use arises from requests from clinicians for individual patients and patients admitted to the hospital on non-formulary medication. There is a process in place for such requests.
   - Use of generic medicines wherever possible. For at least the last 25 years all prescribing in Raigmore Hospital has been by generic drug name unless a specific brand of product was required for good clinical reasons.
   - All medicines are procured, wherever possible, on national contracts negotiated by National Procurement Scotland on our behalf, or by regional contracts via the Northern Region Purchasing Zone, or locally by the Pharmacy Procurement Team. Many high cost new medicines, e.g. Herceptin, cannot be purchased at anything other than the national price set by the pharmaceutical company. This price is often linked to the US market price. All of the 20 most expensive drugs prescribed in Raigmore Hospital are either purchased on a contract or must be purchased at the national price.
   - Unused hospital medicines are returned to Pharmacy and assessed for potential reuse wherever clinically and pharmaceutically acceptable to do so.
   - Pharmacy stock levels or drugs are reviewed to ensure that the range and value of stock held is kept to a safe minimum.

2. Safe and Effective Medicines Use at Individual Patient Level

   - Clinical pharmacists assist with prescribing decisions for individual patients to ensure the best medicine is selected for every patient. Currently only 66% of wards in Raigmore have a regular clinical pharmacy service and most clinics have no pharmacist available at them.
Clinical pharmacists review patient medication profiles to ensure that the combination of medicines prescribed is suitable for the patient, is being appropriately monitored and is cost effective. This includes IV to oral switch of antibiotics where appropriate and prudent use of antimicrobials to help reduce rates of *C. difficile*.

The Medicines Information Team provides information on complex medication related matters for individual patients and groups of patients.

Pharmacy staff assist nursing staff to use patients own drugs (PODs) wherever possible. This service is currently limited to specific wards in Raigmore Hospital but it is more widely available elsewhere, for example in Argyll & Bute hospital wards.

### The Introduction of New Medicines

This is facilitated in the main through the Highland Formulary processes following advice from the Scottish Medicines Consortium (SMC), NHS Quality Improvement Scotland (NHS QIS) and other ad hoc bodies such as the National Plasma Product Expert Advisory Group (NPEAG) in relation to plasma products and some NHS Scotland Risk Share Schemes in relation to very high cost drugs e.g. enzyme replacement therapies for metabolic disorders.

From time to time, clinicians identify patients who have a condition that they think might benefit from a medicine that is not included in the HF. Non-formulary processes including Exceptional Medicines Use policies are then followed (see Appendix 1).

### The Future

The cost of medicines in hospitals will continue to rise due both to increased activity in a number of clinical areas and to the increase in the cost of new medicines. Successive medicines in all disciplines cost more than the medicines they supersede. This is due to the increased cost of bringing drugs to market which is most pronounced in the case of biological therapies. Unfortunately, there is little scope for replacement of current very expensive medicines such as the biological therapies with generic products within the next 5 years.

As well as increased prescribing activity within an ageing population, new drugs are devised for an ever widening range of conditions and sub-conditions as the understanding of disease grows. Therapeutic creep is another area of concern. As new evidence arises, existing drugs stray into new areas or previously untreated segments of the diseased population may now benefit from the existing treatment, all of which increases the range of indications for prescribing.

Some medicines are now turning what were once illnesses with poor prognoses such as HIV and some cancers into chronic conditions, necessitating long term treatment with expensive medicines. If one medicine fails now, then there are two or three others that could also be tried, extending the number of therapeutic options well beyond that even five years ago.

### 3 Contribution to Board Objectives

Prescribing drug therapy is the most common healthcare intervention and forms a key component of the management of many acute and long term conditions. Prescribing therefore has the potential to contribute substantially to the achievement of *Better Health, Better Care, Better Value*. Safe and cost effective prescribing specifically facilitates the achievement of a very broad spectrum of NHS Highland’s Corporate Objectives for 2009-2010, as follows:

#### Better Health: Improve the health and wellbeing of the NHS Highland population.

Corporate objectives: BH.1, BH.2, BH.3, and BH.5

#### Better Care: Maximise the delivery of quality healthcare in the most appropriate setting.

Corporate objectives: BC.1, BC.2, BC.3, BC.4 and BC.5
Better Value: All services are efficient and cost effective.

Corporate objectives: BV.1, BV.2, BV.3, BV.4 and BV.5

4 Governance Implications

Like many other aspects of healthcare provision, prescribing has to strike the right balance between clinical and financial governance. It could be argued that prescribing guidance at both national and local levels is subject to a more robust evidence-based approach than many other forms of healthcare intervention. Where prescribing guidance is implemented therefore, drug therapy should be cost effective. At national level, this is greatly facilitated by the work of organisations such as the Scottish Medicines Consortium (SMC), the National Institute for Clinical Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and NHS Quality Improvement Scotland (NHS QIS). At local level, the Board’s Area Drugs & Therapeutics Committee (ADTC) and its Formulary Subgroup (FSG) in particular ensure that national evidence-based prescribing guidance is translated into appropriate local prescribing guidance in order to underpin safe and cost effective prescribing for patients in NHS Highland. This work is complemented by the other 6 subgroups of the ADTC. There is active public and patient involvement throughout ADTC processes in order to ensure effective representation.

All prescribers have available to them up-to-date evidence-based prescribing guidance through the Highland Formulary (available electronically and paper-based) and through a range of NHS Highland policies, procedures and Patient Group Directions.

Evidence-based policies and guidance are backed on the ground by CHP Lead Pharmacists and their prescribing support pharmacist teams in the community and by clinical pharmacists in hospitals.

A focus on cost effectiveness by these practitioners through a range of different measures helps to release funding to support early adoption of new expensive but effective medicines. Some of these innovative new medicines are improving care for existing patients whilst others are being used to treat patients for whom previously there was little or no effective drug therapy.

It seems highly probable, if not inevitable, that the cost of new, effective and complex drug treatments in the years ahead is set to increase the proportion of NHS Board budgets consumed by prescribing costs, as well as impacting on staffing costs and the cost of associated investigations. As we travel through a period of increasing financial constraint within the public sector, this will make it challenging for NHS Boards to maintain the balance between clinical and financial governance. This may necessitate a new approach to budgeting in order to accommodate the early adoption of effective new drug treatments for patients in NHS Highland.

5 Impact Assessment

An EQIA is not necessary as the report describes governance structures and practice processes underpinning safe and cost effective prescribing together with illustrating some of the initiatives used. The report also updates the Board on the drugs budget financial position.

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20 November 2009
Appendix 1
DRAFT Process for NHS Prescribing of Medicines to Individual Patients in NHS Highland

Prescriber wishes to prescribe medicine for individual patient

Is medicine in Highland Formulary?

Yes

PRESCRIBE
in accordance with Highland Formulary guidance

No

Has SMC/NHS QIS accepted this medicine for the proposed indication and dose in this patient?

Yes

Refer to 'Highland Formulary Process for Medicines' (see Formulary webpage on NHS Highland Intranet)

No

Refer to 'Highland Formulary Process for Medicines' (see Formulary webpage on NHS Highland Intranet)

Is medicine in Highland Formulary?

Yes

Is medicine in process of being assessed by SMC?

Yes

AWAIT
SMC guidance before prescribing in NHS Highland

No

Has National PASAG approved this medicine?

Yes

Can you await SMC guidance before prescribing?

Yes

PRESCRIBE
within national agreement for Patient Access Scheme

No

No

(considered but not accepted)

KEY
SMC: Scottish Medicines Consortium
NHS QIS: NHS Quality Improvement Scotland
PASAG: Patient Access Schemes Advisory Group

Refer to NHS Highland ‘Policy for requests to prescribe medicines, which are not normally recommended for use, for individual patients in NHS Highland’ (see Policy Library on NHS Highland Intranet)