The Royal Society of Medicine
Journal of the Royal Society of Medicine; 2019, Vol. 112(1) 4–5
DOI: 10.1177/0141076818808429

Six months on: NHS England needs to focus on dissemination, implementation and audit of its low-priority initiative

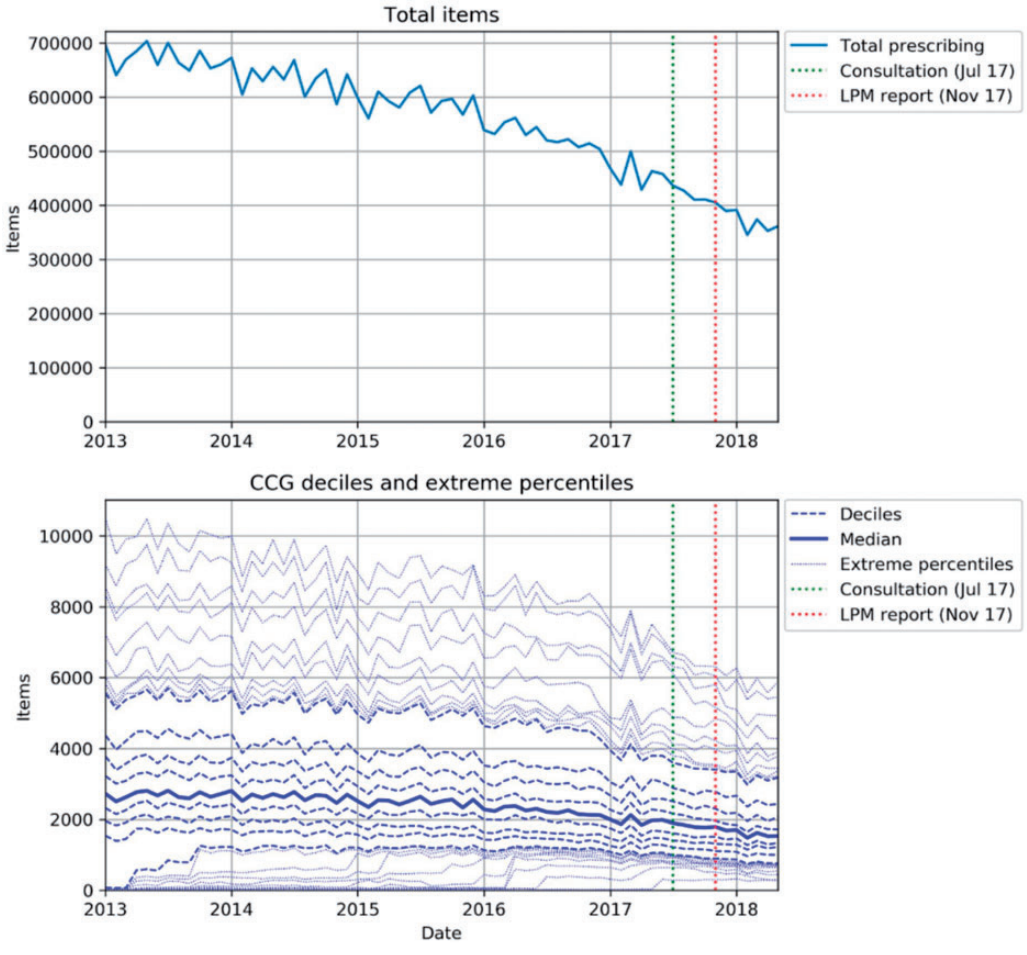
The NHS England low-priority medicines initiative 2017 described a range of medicines that should not be routinely prescribed in primary care. We previously described trends and variation in prescribing for the medications covered.[1] Six months on, we set out to describe how prescribing has changed.

We used the same methodology as before, but with prescribing data updated to May 2018. We examined data on 'number of items prescribed', rather than expenditure, as price fluctuations may otherwise obfuscate changes in clinicians' prescribing choices.

Although there was a reduction in overall use of these medicines (Figure 1), that reduction is in line with the existing downward trend, with no change either after the announcement of the consultation on the scheme (July 2017) or publication of the subsequent consultation report (November 2017). Full results can be seen in our figshare repository.[2]

The same pattern is seen for most individual drugs or classes covered by the initiative (online supplementary Figures 2-18). There is a drop in travel vaccine prescriptions, which coincides with the announcement of the consultation (online supplementary Figure 17) and can be observed across most Clinical Commissioning Groups and a drop in lutein and

Figure 1. Trends and variation in total number of items prescribed across all areas of NHS England low-priority medicines initiative 2017.



antioxidants coinciding with the publication of the report (online supplementary Figure 10), which seems to be mediated by change in very high-prescribing Clinical Commissioning Groups.

In summary: in most cases, NHS England advising doctors to stop prescribing a drug, in a report and consultation, is not sufficient to cause a noticeable change in clinical practice at a national level.

This reflects our own wider work on trends and variation in care, and the drivers for change, raising issues far beyond cost-saving initiatives.[3] The NHS would do well to invest in better ways to disseminate, implement and audit guidance.

Declarations

Conflicts of Interest

BG has received research funding from the Laura and John Arnold Foundation, the Wellcome Trust, the Oxford Biomedical Research Centre, the NHS National Institute for Health Research School of Primary Care Research, the Health Foundation and the World Health Organisation; he also receives personal income from speaking and writing for lay audiences on the misuse of science. RC, AJW, HC, SB are employed on BG's grants for OpenPrescribing. BM is seconded to the DataLab from NHS England and worked on the NHS England low-priority prescribing initiative.

ORCID iD

Alex J Walker http://orcid.org/0000-0003-4932-6135
Brian MacKenna http://orcid.org/0000-0002-3786-9063

References

1. Walker AJ, Curtis HJ, Bacon S, Croker R and Goldacre B. Trends and variation in prescribing of low-priority treatments identified by NHS England: a cross-sectional study and interactive data tool in English primary care. *J R Soc Med* 2018; 111: 203–213.
2. Walker AJ and Goldacre B. *Has the NHS England "Low-Value medicines" initiative had an impact on prescribing? Figshare*, See http://doi.org/10.6084/m9.figshare.6984296 (last checked 12 October 2018).
3. Curtis HJ, Walker AJ and Goldacre B. Impact of NICE guidance on tamoxifen prescribing in England 2011–2017: an interrupted time series analysis. *Br J Cancer* 2018; 118: 1268–1275.

Alex J Walker, Seb Bacon, Helen Curtis, Richard Croker, Brian MacKenna and Ben Goldacre
The DataLab, Nuffield Department of Primary Care Heath Sciences, Radcliffe Observatory Quarter, University of Oxford, Oxford OX2 6GG, UK
Email: ben.goldacre@phc.ox.ac.uk

Professional attitudes killing off primary care

Grey et al.[1] are correct in their defence of general practice. But I wish to add to my charge sheet that over the last few decades, doctors' training has been driven by perceived litigation threats, thereby abolishing the concept the generalist. After 10 years of training, GPs feel they are still not qualified unless they gain further tickets for everyday procedures within a practice, creating micro-specialists. Younger doctors are only comfortable working behind large teams, preferably part-time and without ownership of practices and the responsibility that it entails. My comment[2] that GPs should move into hospital was a nod to these forces that are changing medical practice. Somehow, we must work with these trends arising from within the profession. To resist is futile.

Declarations

Competing Interests: None declared.

References

1. Gray DP, Sidaway-Lee K, Evans P and Harding A. The strengths of general practice. *J R Soc Med* 2018; 111: 264.
2. Bulger G. Contract and ownership type and patient experience. *J R Soc Med* 2018; 111: 80.

Gerard Bulger
HMP Belmarsh, London SE28 0EB, UK
Email: gerard@bulger.co.uk