Published: June 2026

BMA England

Focus on.....
Switching off medicines optimisation software and professional autonomy in acute prescribing

Following the imposition of changes to the GMS contract for 2026/27, rejected by 99% of respondents in a referendum of BMA GP members, and a subsequent failure to satisfactorily resolve two immediate issues in relation to mandated use of Advice and Guidance and use of online consultation software, collective action for GP practice began on 1st May, with a plan to escalate action to introduce a new action each month.

This started with a request for practices to submit a template letter to their ICB, further details of which can be found here

For June, practices will be asked to make acute prescribing choices in the best interests of their patients, regardless of local ICB's formulary choices.

Altering the use of Medicines Optimisation Software

Medicines optimisation software is often embedded by the local ICB for the purposes of system financial savings and/or rationing (rather than the clinical benefit of your patients). It provides prompts, alerts, or recommendations at the point of prescribing. In practice, it often does things like:

- flag cheaper alternatives
- suggest formulary-preferred medicines
- highlight prescribing guidance
- prompt reviews or switches
- warn about duplicate or potentially unsuitable prescribing

These tools are also commonly linked to ICB or local formulary policies, which are often written with cost and ICB prescribing budgets in mind.

Clinical systems provide advice and guidance at the time of prescribing which protects patient safety.

Why are we doing this?

This software can often produce nuisance pop-ups on the screen during patient consultations. These pop-up suggestions may not always be in the patient's best interest as they are often used for financial purposes in order help manage ICB prescribing budgets.

Does this impact on my contract?

There is no requirement within the core GMS contract that require the use of medicines optimisation software. However, it's use may be required as part of a locally commissioned service (LCS).

How do we switch off the software?

Medicines Optimisation Software is usually integrated directly into the primary clinical systems (EMIS Web or SystmOne), so switching it off requires an administrator or manager with appropriate system configuration privileges.

How do I find out if use such software is embedded within a Locally Commissioned Service and what do I do if so?

Practices will need to closely review any LCS that they may be currently signed up to. Your LMC will be able to advise on this as it may be possible to 'decouple' the software from the LCS. Caution is required here though to ensure significant funding from an LCS is not put at risk.

Does this impact on our GMC Good Medical Practice responsibilities?

No - prescribing decisions must be clinically appropriate, patient-centred and capable of justification, and GPs should make good use of the resources available to them, but switching off/ignoring medicines optimisation software does not contradict the requirements as set out with the GMP guidance.

Will this impact on patient care?

This should have minimal direct impact upon patient care. It is recommended that practices do not switch patient medications on this basis and only follow this action for new prescriptions.

Disabling these cost-saving prompt tools does not turn off essential patient safety alerts. The core clinical safety features, such as severe drug interaction warnings, allergy alerts and high-dose triggers are built directly into the EMIS and SystmOne software and will remain fully operational to protect patient safety.

Does this replace the action from May?

This action is in addition to the collective action we proposed in May with regards to asks of ICBs re use of clinical data and Data Sharing Agreements. Escalatory actions will follow each month should a satisfactory resolution with DHSC/NHSE not be forthcoming.

What other action is there?

Amend your acute prescriptions to safe and acceptable alternatives. You will know what is best for your patient within a consultation - but examples may include issuing a liquid suspension rather than a tablet formation (e.g. for those infants requiring a PPI) or a branded product over a generic formulation (e.g. Calpol for paracetamol).

The GMC is clear that doctors should use NHS resources responsibly, but it is equally clear that our first duty remains to our patients. A GP who chooses between different formulations of a medication—whether tablet, capsule, liquid, branded or generic—may do

so provided that choice is clinically appropriate, safe, evidence-based and acceptable to the patient.

Cost is one legitimate consideration amongst many, but it cannot be the sole determinant of clinical decision-making. It is therefore difficult to accept the increasingly intense focus placed upon marginal prescribing budget variances in general practice when these sums are often dwarfed by the multi-billion-pound annual deficits and overspends seen elsewhere in the NHS.

If we are serious about stewardship of public resources, that conversation must be proportionate, balanced and centred on patient care rather than reducing clinical discretion in general practice.