NHS England

Equality and Health Inequalities – Full Analysis - Items which should not be routinely prescribed in primary care

Document Title: Equalities and Health Inequalities Full Analysis-Items which should not be routinely prescribed in primary care:

Version number: V1

First published: July 2016

To be read in conjunction with the Equalities and Health Inequalities Analysis Guidance, Equality and Health Inequalities Unit, NHS England, July 2016

Prepared by: Equality and Health Inequalities Unit

Classification: OFFICIAL

PART A: General Information

1. Title of project, programme or work:
Items which should not be routinely prescribed in primary care

2. What are the intended outcomes?
Production of commissioning guidance, in partnership with NHS Clinical Commissioners, to advise CCGs on items which should not be routinely prescribed in primary care.

Recommendations will categorise items as one of the following;

- Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
- Items which are clinically effective but where more cost-effective products are available, this includes products that have been subject to excessive price inflation.
- Items which are clinically effective but due to the nature of the product, are deemed a low priority for NHS funding.

3. Who will be affected by this project, programme or work?

- Staff – Primarily primary care prescribers who prescribe items in the finalised guidance. Other staff groups (e.g. community pharmacy staff, secondary care) will also be impacted and will have a role to support patients in changes to their therapies.
- Patients – who receive the prescription for items listed in the guidance
- Partner organisations (e.g. NICE, MHRA etc.). We are using recommendations from partner organisations and they will have a role to play in implementation.

4. Which groups protected by the Equality Act 2010 and/ or groups that face health inequalities are very likely to be affected by this work?

Proposals for CCG commissioning guidance

The 18 defined items within the review could potentially be prescribed to anyone in the population requiring them to treat a medical condition, therefore covering all characteristics. This is the case for all items included, apart from Tadalafil which would only be prescribed to men.

The profile of people who are currently being prescribed each item can only be interrogated accurately for age and sex as national prescribing data (Source: NHS Business Services Authority) is only available for these 2 characteristics. We are therefore only able to demonstrate an accurate profile for individual medications for these 2 characteristics.

Overall this prescribing data for 2016 indicates that on average, more females (61.3%) are prescribed the defined list of medicines than males (38.7%). This indicates that reviews and potential deprescribing may be most commonly required in women for the majority of medications, particularly the pain and depression medications where over 60% of those prescribed these medicines in 2016 were women. 85% of liothyronine prescriptions in 2016 were for women which corresponds with national prevalence for hypothyroidism. Prescribing data for the hypertension drugs see a more equal male/female spilt and omega 3 prescribing in 2016 was more common in men (~ 70%). See 5.1 for more details.

Looking at the age profiles of patients prescribed medications in 2016 (see 5.8) on average, for adults, the prevalence of these medicines increases with age. This pattern is seen in both females and males with no significant differences in prevalence between age groups by gender. In most cases, the proportion of prescriptions for children is very small at around one or two percent, except for herbal (19.3%), and homeopathic medicines (14.7%). The majority of medications were prescribed most frequently to adults aged 45 and over. Three of the medications were prescribed most frequently to over 65 year olds (glucosamine and chondroitin, co-proxamol, and lutein and antioxidants).

A literature review was also undertaken to explore research evidence including prevalence of patient characteristics for disease areas rather than individual medications e.g. chronic pain, hypertension, depression. The aim of this was to explore if there were indications that particular groups may be affected by the guidelines in a more general sense. It should be noted that a caveat to this is that it provides some indication of the general population, although does not provide accurate information about the actual medicines in the review and if these generalisations about particular disease areas would apply to the particular cohorts being prescribed the medications in the review.

Full results can be seen in Appendix A. Overall the evidence indicates that chronic pain increases with age, was higher among females, and in people with disability, low income and low educational level. The evidence also suggests that females may be more likely to report pain and that there are lots of other influencing factors which would affect the epidemiology of different types of chronic pain. Six of the medications in the review are related to management of pain.

Items that are available over the counter

As part of the review NHS Clinical Commissioners and NHS England have also identified a number of products and conditions which fall into wider categories that need to be considered. The NHS in England spends approximately £645million on medicines which can be purchased over the counter from a pharmacy and/or other outlets such as petrol stations or convenience stores.

These product categories include:

- Medicines which are relatively clinically ineffective;
- Medicines which are clinically effective but suitable for self-care and used to treat time-limited/short term conditions;
- Medicines which are clinically effective but suitable for self-care and used to treat longer term, chronic conditions

The consultation plans to ask for views, insight and evidence to inform proposals

The 3 month consultation plans to ask initial questions about the impact of proposed criteria and restrictions to prescribing such items. This will be used to further develop the full equality impact assessment. It is considered that this element of the project may impact those who receive free prescriptions. This will therefore be considered further as part of the full impact assessment for this element of the project. Restrictions may also impact on patients who could be paying a prescription charge for items that are cheaper to buy over the counter.

It is important to note that not doing this work also has an impact on all characteristics. Some of the drugs in the review are shown to be unsafe, ineffective or have a more cost effective alternative. Without review and implementation by CCGs, inequalities to the wider population are likely due to unnecessary variation in prescribing and use of NHS funding on medications which are shown to be of low value. Money used on these products may deflect from using this funding on more evidence based and cost effective treatments. Not undertaking this work could result in inequality for the wider population by not making most effective use of the NHS prescribing budget and NHS budgets more generally.

PART B: Equalities Groups and Health Inequalities Groups

5. Impact of this work for the equality groups listed below.

Focusing on each equality group listed below (sections 5.1. to 5.9), please answer the following questions:

a) Does the equality group face discrimination in this work area?
b) Could the work tackle this discrimination and/or advance equality or good relations?
c) Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
d) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
e) If you cannot answer these questions what action will be taken and when?

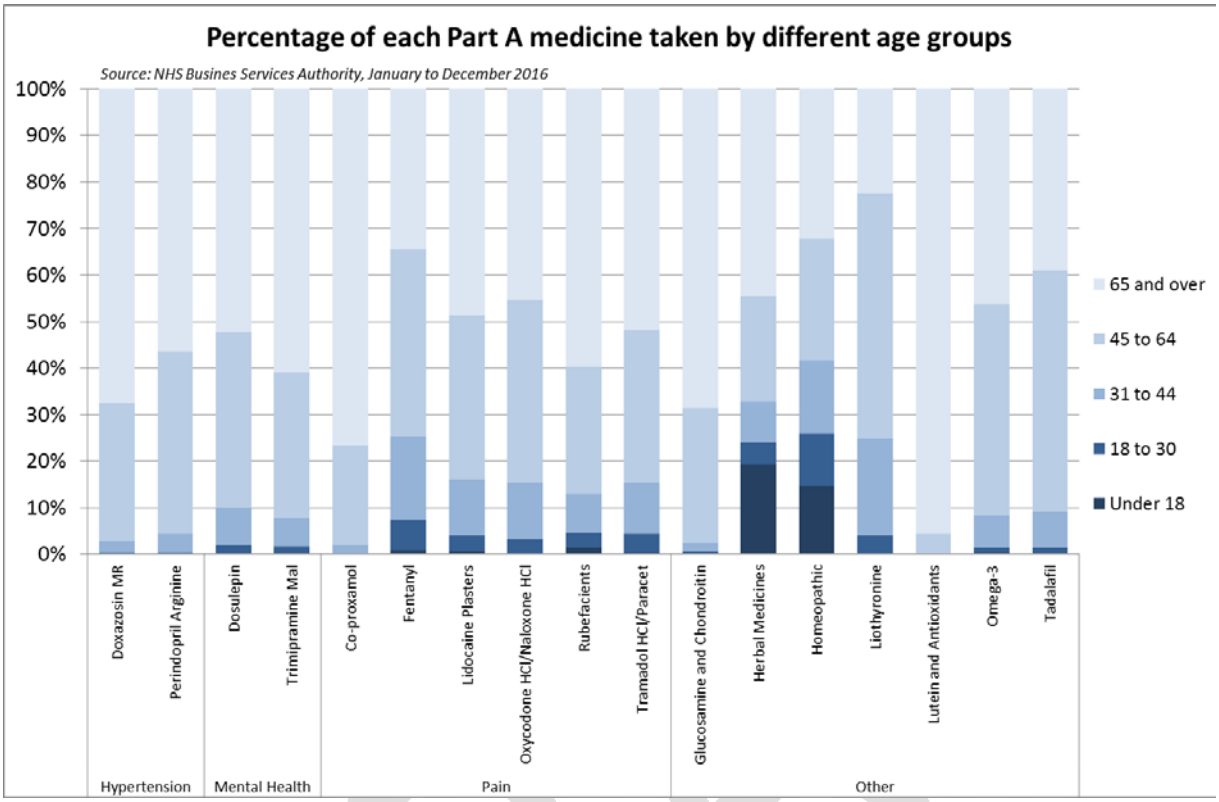
The following addresses prescribing as a whole. For further detail on individual medications please see Appendix A

5.1. Age

Does the equality group face discrimination in this work area?
As people get older they are more likely to be taking prescribed medications however there is no evidence to suggest that this prescribing is due to discrimination and is more likely due to increasing prevalence of various diseases related to increasing age.

Supporting Reference:
http://content.digital.nhs.uk/catalogue/PUB16076/HSE2013-Ch5-pres-meds.pdf

Figure 1. NHS BSA prescribing data 2016 by age (see appendix C for source data)



Could the work tackle this discrimination and/or advance equality or good relations?
Looking at the age profiles of patients prescribed the defined medications in 2016 on average, for adults, the prevalence of these medicines increases with age. This pattern is seen in both females and males with no significant differences in prevalence between age groups by gender. In most cases, the proportion of prescriptions for children is very small at around one or two percent, except for herbal (19.3%), and homeopathic medicines (14.7%). The majority of medications were prescribed most frequently to adults aged 45 and over. Three of the medications were prescribed in 70% of cases to over 65 year olds (glucosamine and chondroitin, co-proxamol, and lutein and antioxidants).

As people of increasing age take prescribed medicines, overall older people will receive more medicines from the category *Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.* This guidance, if adopted by CCGs, should prompt review of treatments meaning more people of an increasing age will receive reviews to optimise their treatment.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
Could assist in potentially reducing harm caused by certain medicines of which older people are more likely to receive.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?

During consultation, responses will be monitored to ascertain if there are any unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

The 3 month consultation will ensure engagement with any specific groups or charities to ensure that older people who may be represented more are adequately able to respond to the consultation.

If you cannot answer these questions what action will be taken and when?
n/a

5.2. Disability

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and disability so we cannot definitively assess fully at a national level. Studies have identified that people with disability are more likely to suffer from chronic pain however it is unknown if this is applicable to the population taking the medications within the review.

Could the work tackle this discrimination and/or advance equality or good relations?
Reviews of medication treatment could be used as an opportunity to optimise medical treatment for people with disabilities.
Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
There is the potential that it could assist in potentially reducing harm caused by certain medicines if a person with a disability is more likely to receive.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
Yes – during consultation, responses will be monitored to ascertain if there are any likely unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve

If you cannot answer these questions what action will be taken and when?

5.3. Gender reassignment

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and gender reassignment so we cannot definitively assess, at a national level, how many people will be affected. None of the items included in the proposed guidance are used for the purposes of gender reassignment.

Could the work tackle this discrimination and/or advance equality or good relations?
Unsure as we cannot accurately assess impact in the national population.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
Unsure as we cannot accurately assess impact in the national population.

Does any action need to be taken to address any important adverse impact? If yes, what

action should be taken?
Yes – during consultation, responses will be monitored to ascertain if there are any likely unintended consequences on the protected characteristic. CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve.

If you cannot answer these questions what action will be taken and when?

5.4. Marriage and civil partnership

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and marriage/civil partnership so we cannot definitively assess, at a national level, how many people in a marriage/civil partnership will be affected. No link between prescribing and marriage/civil partnership has been identified.

Could the work tackle this discrimination and/or advance equality or good relations?
Unsure as we cannot accurately assess impact in the national population.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
Unsure as we cannot accurately assess impact in the national population.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
Yes – during consultation, responses will be monitored to ascertain if there are any likely unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

If you cannot answer these questions what action will be taken and when?

5.5. Pregnancy and maternity

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and pregnancy/maternity so we cannot definitively assess, at a national level, how many people in a pregnancy/maternity partnership will be affected.

None of the items proposed in the guidance are used for conditions that are closely related to pregnancy or maternity. We assume that prescribers will use medications Summary of Product Characteristics to inform treatment if any of these medicines are going to be used in pregnancy to ensure a shared decision is reached.

Could the work tackle this discrimination and/or advance equality or good relations?
Unsure as we cannot accurately assess impact in the national population.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
Unsure as we cannot accurately assess impact in the national population.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
Yes – during consultation, responses will be monitored to ascertain if there are any likely unintended consequences on the protected characteristic. CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve.

If you cannot answer these questions what action will be taken and when?

5.6. Race

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and race so we cannot definitively assess, at a national level, how many people will be affected.

Could the work tackle this discrimination and/or advance equality or good relations?
Unsure as we cannot accurately assess impact in the national population.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
Unsure as we cannot accurately assess impact in the national population.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?

Yes – during consultation, responses will be monitored to ascertain if there are any likely unintended consequences on the protected characteristic. CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve

If you cannot answer these questions what action will be taken and when?

5.7. Religion or belief

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and religious beliefs so we cannot definitively assess, at a national level, how many people will be affected. We have not identified any religious beliefs that would make you more or less likely to receive the items included in the guidance.

Could the work tackle this discrimination and/or advance equality or good relations?
Unsure as we cannot accurately assess impact in the national population.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
Unsure as we cannot accurately assess impact in the national population.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
Yes – during consultation, responses will be monitored to ascertain if there are any likely unintended consequences on the protected characteristic. CCGs will also be required to assess

the impact of their population with regard to the particular demographics of the population they serve

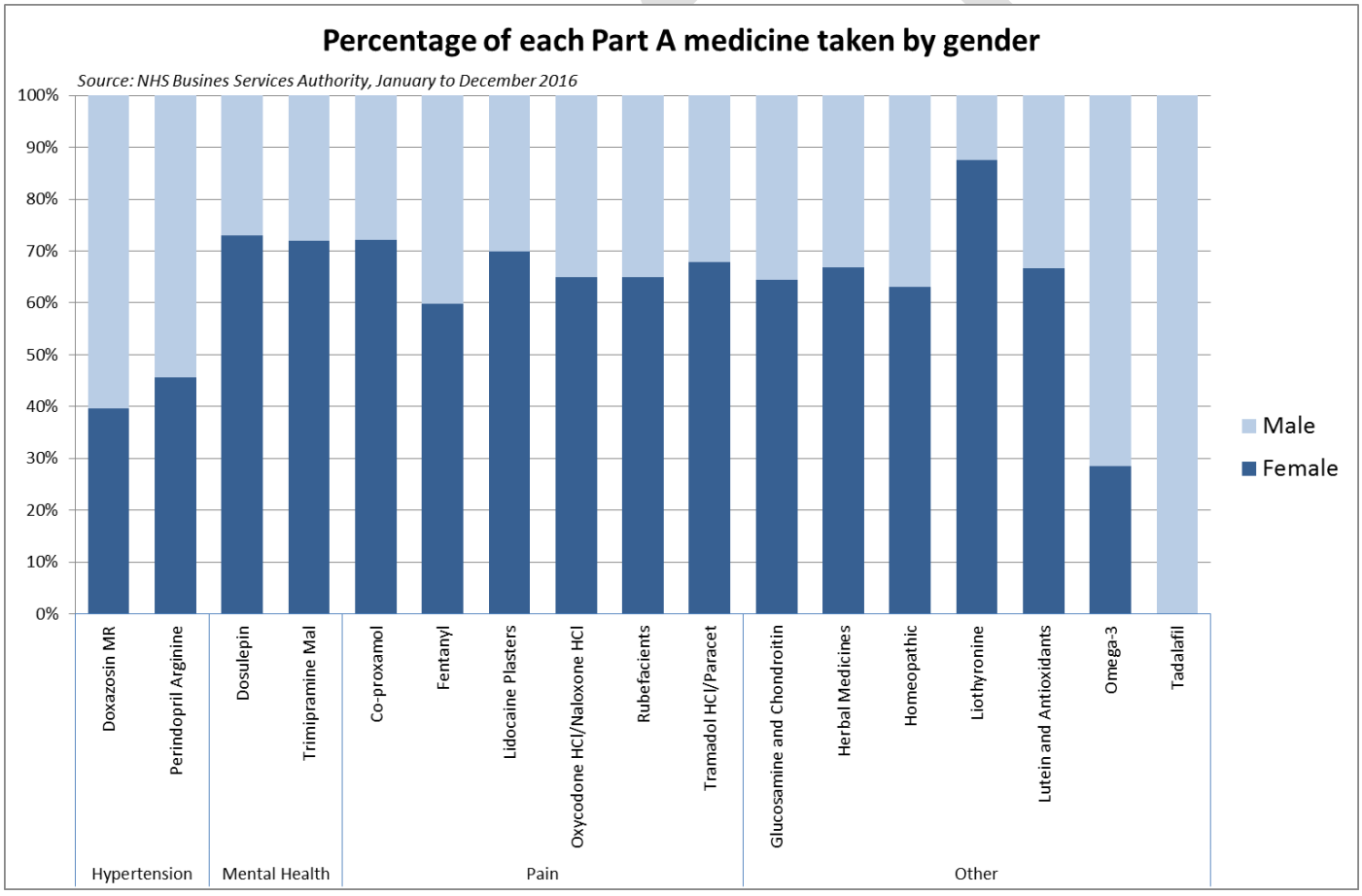
If you cannot answer these questions what action will be taken and when?

5.8. Sex or gender

Does the equality group face discrimination in this work area?
43% of men and 50% of women take at least one prescribed medicine. This proportion is higher among young women than young men but increased with age more sharply in men than women. 22% of men and 24% of women report that they take at least three prescribed and although this proportion increased with age it does not vary by sex.

Source
http://content.digital.nhs.uk/catalogue/PUB16076/HSE2013-Ch5-pres-meds.pdf

Figure 2. NHS BSA prescribing data 2016 by gender (see appendix B for source data)



One item on the list, tadalafil once daily, is used exclusively by men. It falls into the category *Items which are clinically effective but where more cost-effective products are available, this includes products that have been subject to excessive price inflation.* An alternative tadalafil product (i.e. tadalafil "when required") will be available as well as alternative treatments.

Could the work tackle this discrimination and/or advance equality or good relations?

Overall this prescribing data for 2016 indicates that on average, more females (61.3%) are prescribed these medicines than males (38.7%). This indicates that reviews and potential deprescribing may be most commonly required in women for the majority of medications, particularly the pain and depression medications where over 60% of those prescribed these medicines in 2016 were women. 85% of liothyronine prescriptions in 2016 were for women which corresponds with national prevalence for hypothyroidism (Appendix A). Prescribing data for the hypertension drugs see a more equal male/female spilt and omega 3 prescribing in 2016 was more common in men (~ 70%). This guidance, if adopted by CCGs, should prompt review of treatments meaning more people will receive reviews to optimise their treatment from the groups above.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
There is the potential that it could assist in potentially reducing harm caused by certain medicines which particular genders are more likely to receive.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?

During consultation, responses will be monitored to ascertain if there are any likely unintended consequences on the protected characteristic. CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve

The 3 month consultation will ensure engagement with any specific groups or charities to ensure that older people who are represented more are able to respond to the consultation adequately.

If you cannot answer these questions what action will be taken and when?
n/a

5.9. Sexual orientation

Does the equality group face discrimination in this work area?
There is no routinely collected data on prescribing and sexual orientation so we cannot definitively assess, at a national level, how many people will be affected.
There is no established link between prescribing of items proposed in this guidance and sexual orientation.

Could the work tackle this discrimination and/or advance equality or good relations?
Unsure as we cannot accurately assess impact in the national population.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
Unsure as we cannot accurately assess impact in the national population.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
Yes – during consultation, responses will be monitored to ascertain if there are any likely unintended consequences on the protected characteristic. CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve

If you cannot answer these questions what action will be taken and when?

6. Implications of our work for the health inclusion groups listed below.
Focusing on the work described in sections 1 and 2, in relation to each health inclusion group listed below (Sections 6.1. To 6.12), and any others relevant to your work[1], please answer the following questions:

f) Does the health inclusion group experience inequalities in access to healthcare?
g) Does the health inclusion group experience inequalities in health outcomes?
h) Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes?
i) Could the work assist or undermine compliance with the duties to reduce health inequalities?
j) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
k) As some of the health inclusion groups overlap with equalities groups you may prefer to also respond to these questions about a health inclusion group when responding to 5.1 to 5.9. That is fine; please just say below if that is what you have done.
l) If you cannot answer these questions what action will be taken and when?

6.1. Alcohol and / or drug misusers
None of the medicines in the review are specifically used in the treatment of addiction. There is no data available on the prevalence of alcohol of drug users who are currently prescribed the medications in the review.

6.2. Asylum seekers and /or refugees
There is no data available on the prevalence of asylum seekers and/or refugees who are currently prescribed the medications in the review.

6.3. Carers
There is no data available on the prevalence of carers who are currently prescribed the medications in the review.

6.4. Ex-service personnel / veterans
There is no data available on the prevalence of ex-service personnel / veterans who are currently prescribed the medications in the review.

6.5. Those who have experienced Female Genital Mutilation (FGM)
There is no data available on the prevalence of who have experienced Female Genital Mutilation (FGM) who are currently prescribed the medications in the review.

6.6. Gypsies, Roma and travellers
There is no data available on the prevalence of Gypsies, Roma and travellers who are currently prescribed the medications in the review.

6.7. Homeless people and rough sleepers

[1] Our guidance document explains the meaning of these terms if you are not familiar with the language.

There is no data available on the prevalence of homeless people and rough sleepers who are currently prescribed the medications in the review.

6.8. Those who have experienced human trafficking or modern slavery

There is no data available on the prevalence of those who have experienced human trafficking or modern slavery who are currently prescribed the medications in the review.

6.9. Those living with mental health issues

Two medicines that are being proposed in the guidance, dosulepin and trimipramine, are used for the treatment of mental health conditions. There are significant safety concerns with dosulepin, so by optimising people's treatment for mental health it may improve outcomes and reduce the chance of a person with mental health issues experiencing a negative safety impact from their prescribed medicines. Trimpramine is not a recognised first line treatment for mental health issues so by having a review of treatment it may identify more appropriate treatment options.

The ONS releases an annual report on the numbers of people who died in the previous year from poisoning which includes suicides. There is good evidence (World Health Organisation) that reducing access to means (including toxic medications) can reduce deaths from suicides. From the items being proposed in the guidance; co-proxamol, fentanyl and dosulepin are all analysed individually in the report showing deaths. Deaths related to Trimipramine, tramadol and paracetamol combination, oxycodone and naloxone could be included but due to the way the data is presented it is not possible to definitively identify. Reducing prescribing of these medicines can potentially contribute in reducing access to means and therefore deaths from suicides.

6.10.Sex workers

There is no data available on the prevalence of sex workers who are currently prescribed the medications in the review.

6.11.Trans people or other members of the non-binary community

There is no data available on trans people or other members of the non-binary community who are currently prescribed the medications in the review.

6.12.The overlapping impact on different groups who face health inequalities

There is no data available on different groups who face health inequalities who are currently prescribed the medications in the review.

7. Other groups that face health inequalities that we have identified.

Have you have identified other groups that face inequalities in access to healthcare?
Our consultation will be used to evaluate the impact on other groups.

Does the group experience inequalities in access to healthcare and/or inequalities in health outcomes?
n/a as above

Short explanatory notes - other groups that face health exclusion.
As we research and gather more data, we learn more about which groups are facing health

inequalities. If your work has identified more groups that face important health inequalities please answer questions 7 and 8. Please circle as appropriate.

If you have not identified additional groups, that face health inequalities, just say not applicable or N/A in the box below.

Yes Complete section 8	**No** Go to section 9	N/A

N/A

8. Other groups that face health inequalities that we have identified.
Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes in relation to these other groups that face health inequalities?
Could the work undermine compliance with the duties to reduce health inequalities and, if so, what action should be taken to reduce any adverse impact?
Is the work going to help NHS England to comply with the duties to reduce health inequalities?
If you have identified other groups that face health inequalities please answer the questions below. You will only answer this question if you have identified additional groups facing important health inequalities

PART C: Promoting integrated services and working with partners

Short explanatory notes: Integrated services and reducing health inequalities.

Our detailed guidance explains the duties in relation to integrated services and reducing health inequalities. Please answer the questions listed below.

9. Opportunities to reduce health inequalities through integrated services.

Does the work offer opportunities to encourage integrated services that could reduce health inequalities? If yes please also answer 10.

Yes Go to section 10	**No** Go to section 11	Do not know

No

10. How can this work increase integrated services and reduce health inequalities?

Please explain below, in a few short sentences, how the work will encourage more integrated services that reduce health inequalities and which partners we will be working with.

PART D: Engagement and involvement

11. Engagement and involvement activities already undertaken.

How were stakeholders, who could comment on equalities and health inequalities engaged, or involved with this work? For example in gathering evidence, commenting on evidence, commenting on proposals or in other ways? And what were the key outputs?

NHS England established a working group in partnership with NHS Clinical Commissioners with membership from their own organisations plus partner organisations. On June 13 a stakeholder session with wider partners and patient groups was invited to contribute their views on the proposals. The attendance at this meeting included representatives of;

- National Voices
- Healthwatch
- Patient Association
- BMA-GPC
- Royal Pharmaceutical Society
- BGMA
- APBI

- PrescQIPP

Comments and suggestions were received on how to consult and reach further group affected by the proposals.

12. Which stakeholders and equalities and health inclusion groups were involved?

NHS England, NHS Clinical Commissioners, Royal Pharmaceutical Society, NICE, Department of Health, PrescQIPP NHS Buisness Services Authority, Royal College of GPs, Academy of Medical Royal Colleges, National Voices, Patients Association, Healthwatch.

13. Key information from the engagement and involvement activities undertaken.

Were key issues, concerns or questions expressed by stakeholders and if so what were these and how were they addressed? Were stakeholders broadly supportive of this work?

Stakeholders were broadly supportive of the work on the proposals for the initial list of 18 items and did not raise particular concerns about any of the protected characteristics for the defined list of medications. As part of the consultation we will ask our stakeholders for their views on items that available over the counter and consult with them on development of detailed proposals.

14. Stakeholders were not broadly supportive but we need to go ahead.

If stakeholders were not broadly supportive of the work but you are recommending progressing with the work anyway, why are you making this recommendation?

There are currently no recommendations on the self-care/OTC element of the project. A full Equality and Health Inequality Impact assessment will be undertaken on this element in light of the 3 month consultation which will ask initial questions about groups potentially affected by any changes to prescription of such items.

15. Further engagement and involvement activities planned.

Are further engagement and involvement activities planned? If so what is planned, when and why?

NHS England is planning a full 3 month consultation to allow other groups and individuals to comment on the proposals. This will involve a web consultation (including accessible version and easy read options) plus further consultation activity designed to ensure that people have the opportunity to provide their views. This will involve working with current stakeholders and other charities and patient groups.

PART E: Monitoring and Evaluation

16. In relation to equalities and reducing health inequalities, please summarise the most important monitoring and evaluation activities undertaken in relation to this work

Evaluation plan is being developed and consideration will be given to inequalities monitoring. For example we can monitor age and sex of all people on these medicines.

17. Please identify the main data sets and sources that you have drawn on in relation to this work. Which key reports or data sets have you drawn on?

NHS Business Services Authority (BSA) prescribing data, Jan – Dec 2016.

http://content.digital.nhs.uk/catalogue/PUB16076/HSE2013-Ch5-pres-meds.pdf
http://content.digital.nhs.uk/catalogue/PUB23631/pres-cost-anal-eng-2016-rep.pdf

Please see appendix A for further evidence and literature references and sources.

18. Important equalities or health inequalities data gaps or gaps in relation to evaluation.

In relation to this work have you identified any:

- important equalities or health inequalities data gaps or
- gaps in relation to monitoring and evaluation?

Yes	No

There is currently no nationally collected data for 7 or the 9 characteristics and additional health improvement groups for the individual medications in this review.

19. Planned action to address important equalities or health inequalities data gaps or gaps in relation to evaluation.

If you have identified important gaps and you have identified action to be taken, what action are you planning to take, when and why?

This is something that individual CCGs may have more insight on when looking at their local population data and will be encouraged to consider this as part of local consultation and impact assessment.

PART F: Summary analysis and recommended action		
20. Contributing to the first PSED equality aim. Can this work contribute to eliminating discrimination, harassment or victimisation?		
Yes	**No**	Do not know
If yes please explain how, in a few short sentences		
N/A		
21. Contributing to the second PSED equality aim. Can this policy or piece of work contribute to advancing equality of opportunity? Please circle as appropriate.		
Yes	No	Do not know
Currently patients could be receiving medications that are unsafe, ineffective or where there is a more cost effective alternative available. By setting a national direction on a set of defined medications this project encourages CCGs to implement policy that encourages review of patients taking these medications to ensure that their treatment is optimised. The enables patients to have access to the most effective medications to achieve the best outcomes. If more cost effective options are utilised this frees up funding for other care and treatment to optimise wider population benefit and outcomes.		
22. Contributing to the third PSED equality aim. Can this policy or piece of work contribute to fostering good relations between groups? Please circle as appropriate.		
Yes	No	Do not know
The Low Value Medicines working group includes representatives from NHSCC, CCG medicines optimisation teams, NICE etc. We are also working with other stakeholders as described in question 12. The common aim to ensure that the CCG guidance developed supports CCGs in effective medicines optimisation for the population they serve. Fostering of good relationships will also be enhanced through engagement with a number of other stakeholders including charities and patient groups. The consultation also provides an opportunity for organisations, health professionals, patients and the public to be considered in the development of the CCG guidance.		

23. Contributing to reducing inequalities in access to health services.

Can this policy or piece of work contribute to reducing inequalities in access to health services?

Yes	No	Do not know

Currently patients could be receiving medications that are unsafe, ineffective or where there is a more cost effective alternative available. By setting a national direction on a set of defined medications this project encourages CCGs to implement policy that encourages review of patients taking these medications to ensure that their treatment is optimised. The enables patients to have access to the most effective medications to achieve the best outcomes. If more cost effective options are utilised this frees up funding for other care and treatment to optimise wider population benefit and outcomes.

Patients currently taking the medication will benefit. If CCGs implement the guidance once finalised, all patients being prescribed the included medications should be considered for medication review aiming to optimise their treatment and outcomes. There are also wider population gains than those who may benefit from the more efficient use of the money currently spent on low value medicines.

CCGs will need to consider this national impact assessment and the report form the national consultation when undertaking their own consultation and impact assessment as part of local implementation. This will help ensure that specific groups locally are not impacted adversely.

24. Contributing to reducing inequalities in health outcomes.

Can this work contribute to reducing inequalities in health outcomes?

Yes	No	Do not know

See section 23.

25. Contributing to the PSED and reducing health inequalities.

How will the policy or piece of work contribute to the achieving the PSED and reducing health inequalities in access and outcomes? Please describe below in a few short sentences.

As section 23

26. Agreed or recommended actions.

What actions are proposed to address any key concerns identified in this Equality and Health Inequalities Analysis (EHIA) and / or to ensure that the work contributes to the reducing unlawful discrimination / acts, advancing equality of opportunity, fostering

good relations and / or reducing health inequalities? Is there a need to review the EHI analysis at a later stage?				
Action	Public Sector Equality Duty	Health Inequality	By when	By whom
Consider and reference NICE Equality Impact Assessments already undertaken – a number of the proposed recommendations reflect NICE guidance 'do not do' recommendations	Yes	Yes	Ongoing	Project team
Ensure that CCGs are encouraged to consider their local demographic and prescribing data available to ensure that local implementation decisions are effective and in line with legislation.	Yes	Yes	Post national consultation	CCGs
Support implementation with resources referenced in the guidance to support prescribers with deprescribing and offer of alternative medication where appropriate.	Yes	Yes	Post consultation	Project team LVM working group
Continue to gather intelligence to support review of the E&HI Impact assessment throughout the 3 month consultation period.	Yes	Yes	July – Oct 2017	Project team
Use initial insight from the consultation to develop the full equalities and health inequalities impact assessment for over the counter medicines proposals.	Yes	Yes	July – Oct 2017	Project team
Continue to work with key stakeholders as described in the document to ensure that commissioning and clinical advice is fed into the guideline development alongside the	Yes	Yes	Ongoing	Project team and stakeholders

consultation feedback.				
Continue to engage and work with key patient groups and charities as part of the consultation to ensure groups identified in the document are provided with an opportunity to contribute towards the consultation and guidance development.	Yes	Yes	Ongoing	Project team and stakeholders
Via the consultation communications plan promote the consultation effectively to ensure that groups suggested by the assessment as most effected have the opportunity to contribute to and shape the CCG guidance.	Yes	Yes	July/Aug 2017	Project team

Appendix A

Equalities and Health Inequalities Evidence Search

Pain (Co-proxamol, Lidocaine Plasters, Rubefacients, Fentanyl Immediate Release, Paracetamol & Tramadol, Oxycodone & Naloxone)

The following evidence does indicate that the prevalence of chronic pain increases with age, was higher among females, and in people with disability, low income and low educational level. The evidence also suggests that females may be more likely to report pain and that there are lots of other influencing factors which would affect the epidemiology of different types of chronic pain. The draft recommendations for all of the pain medications ensure that patients would be offered a suitable alternative. Where required this would involve an MDT of other health professionals. There are no recommendations that result in patients being disadvantaged by offering no pain relief or an alternative that was not agreed collaboratively by the patient and clinician.

For the recommendations that reflect NICE guidance an equality impact assessment has been undertaken as part of the development of this guideline as follows:

- NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (includes Lidocaine plasters)
- NICE CG177 Osteoarthritis (includes do not do for rubefacients)
- NICE CG140 Opioids in Palliative Care (includes fentanyl immediate release)

Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies (Fayaz, 2016)
The prevalence of chronic pain, derived from 7 studies, ranged from 35.0% to 51.3% (pooled estimate 43.5%, 95% CIs 38.4% to 48.6%). The prevalence of moderate-severely disabling chronic pain (Von Korff grades III/IV), based on 4 studies, ranged from 10.4% to 14.3%. 12 studies stratified chronic pain prevalence by age group, demonstrating a trend towards increasing prevalence with increasing age from 14.3% in 18–25 years old, to 62% in the over 75 age group, although the prevalence of chronic pain in young people (18–39 years old) may be as high as 30%. Reported prevalence estimates were summarised for chronic widespread pain (pooled estimate 14.2%, 95% CI 12.3% to 16.1%; 5 studies), chronic neuropathic pain (8.2% to 8.9%; 2 studies) and fibromyalgia (5.4%; 1 study). Chronic pain was more common in female than male participants, across all measured phenotypes.

National pain audit (2013)
The prevalence of chronic pain is estimated at 8-60% of the population, depending on the definition3. Severe pain is estimated at 11% for adults and 8% for children. Older age, female sex, poor housing and type of employment (for example heavy manual work) are significant predictors of chronic pain in the community.

The epidemiology of chronic pain in the community (1999, Elliott et al)
A survey in Scotland (n = 3605) identified age, sex, housing tenure, and employment status as significant predictors of the presence of chronic pain in the community.

https://www.ncbi.nlm.nih.gov/pubmed/11166468
Chronic pain in Australia: a prevalence study (Blyth et al, 2001)
This study reports chronic pain prevalence in a randomly selected sample of the

adult Australian population. Data were collected by Computer-Assisted Telephone Interview (CATI) (n = 17,543) Having chronic pain was significantly associated with older age, female gender, lower levels of completed education, and not having private health insurance; it was also strongly associated with receiving a disability benefit (adjusted OR=3.89, P<0.001) or unemployment benefit (adjusted OR=1.99, P<0.001); being unemployed for health reasons (adjusted OR=6.41, P<0.001); having poor self-rated health (adjusted OR=7.24, P<0.001); and high levels of psychological distress (adjusted OR=3.16, P<0.001).

http://ovidsp.uk.ovid.com/sp-3.25.0a/ovidweb.cgi?&S=HBIEPDNJPPHFFLLOFNGKOHEGHGHAAA00&Abstract=S.sh.91%7c99%7c1

Chronic pain: One year prevalence and associated characteristics, the HUNT pain study (Elsevier, 2013)

The total prevalence of chronic pain was 36% (95% CI 34-38) among women and 25% (95% CI 22-26) among men. The prevalence increased with age, was higher among people with high BMI, and in people with low income and low educational level.

http://ovidsp.uk.ovid.com/sp-3.25.0a/ovidweb.cgi?&S=HBIEPDNJPPHFFLLOFNGKOHEGHGHAAA00&Complete+Reference=S.sh.91%7c405%7c1

The prevalence of chronic pain in united states adults: Results of an internet-based survey (Johannas, 2010)

A cross-sectional, Internet-based survey was conducted in a nationally representative sample of United States (US) adults to estimate the point prevalence of chronic pain and to describe sociodemographic correlates and characteristics of chronic pain (n = 27,035). The weighted point-prevalence of chronic pain (defined as chronic, recurrent, or long-lasting pain lasting for at least 6 months) was 30.7% (95% CI, 29.8-31.7). Prevalence was higher for females (34.3%) than males (26.7%) and increased with age. Multiple logistic regression analysis identified low household income and unemployment as significant socioeconomic correlates of chronic pain. Chronic pain is prevalent among US adults and is related to indicators of poorer socioeconomic status

Gender considerations in the epidemiology of chronic pain (LeResche, 1999)

Indicates age and sex differences for different types of chronic pain conditions. Some indication that women may be more likely to report chronic pain, although this may not be a true indication of cases in the population.

Omega-3

NICE have undertaken an equality impact assessment for each of their guidelines where the 'do not do' recommendations originate from these are referenced as follows. The recommendations for Omega- 3 are reflecting the NICE recommendations.

MI secondary prevention
https://www.nice.org.uk/guidance/cg172/documents/mi-secondary-prevention-update-equality-impact-assessment-form2

Cardiovascular disease: risk assessment and reduction, including lipid modification
https://www.nice.org.uk/guidance/cg181/documents/lipid-modification-update-equality-impact-assessment-form-scoping2

Familial hypercholesterolaemia: identification and management
https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjJ0eybkM_UAhUFKVAKHTogBLMQFggIMAA&url=https%3A%2F%2Fwww.nice.org.uk%2Fguidance%2Fgid-cgwave0825%2Fdocuments%2Fequality-impact-assessment&usg=AFQjCNEaNBGaVw2HH8wQ60MkqRVqm7Fg3Q

Non-alcoholic fatty liver disease (NAFLD): assessment and management
https://www.nice.org.uk/guidance/ng49/documents/equality-impact-assessment-2
https://www.nice.org.uk/guidance/ng49/documents/equality-impact-assessment-3

Autism spectrum disorder in under 19s: support and management
https://www.nice.org.uk/guidance/cg170/documents/autism-management-of-autism-in-children-and-young-people-guideline-eia2

Multiple sclerosis in adults: management
https://www.nice.org.uk/guidance/cg186/documents/multiple-sclerosis-2014-equality-impact-assessment-scoping2

Mental Health (Dosulepin, Trimpramine)

The following evidence does indicate that common mental health disorders are more prevalent which some of the protected characteristics (see below for details). The draft recommendations for the above medications ensure that patients would be offered a suitable alternative. Where required this would involve an MDT of other health professionals. There are no recommendations that result in patients being disadvantaged by offering no alternative or one that was not agreed collaboratively by the patient and clinician.

The recommendations reflect NICE guidance on depression in adults and an equality impact assessment has been undertaken as part of the development of this guideline.

https://www.nice.org.uk/guidance/gid-cgwave0725/documents/equality-impact-assessment-2

https://www.nice.org.uk/guidance/gid-cgwave0725/documents/equality-impact-assessment-3

McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016). Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014**. Leeds: NHS digital.**

One in three adults aged 16-74 (37 per cent) with conditions such as anxiety or depression, surveyed in England, were accessing mental health treatment, in 2014. This figure has increased from one in four (24 per cent) since the last survey was carried out in 2007. Overall, around one in six adults (17 per cent) surveyed in England met the criteria for a common mental disorder (CMD) in 2014.

Women were more likely than men to have reported CMD symptoms. One in five women (19 per cent) had reported CMD symptoms, compared with one in eight men (12 per cent). Women were also more likely than men to report severe symptoms of CMD - 10 per cent of women surveyed reported severe symptoms compared to 6 per cent of men.

Age
CMD symptoms were associated with age. Overall, working-age people were around twice as likely to have symptoms of CMD as those aged 65 and over. Between 16 and 64, the proportion with CMD symptoms remained around 17%–18%. But among those aged 65 and over the rate was much lower
(10.2% of 65 to 74 year olds and 8.1% of those aged 75 and over). A similar pattern was observed for severe symptoms of CMD.

Ethnic group
In men, prevalence of CMD did not vary significantly by ethnic group, whereas it did in women. Using age-standardised figures, non-British White women were less likely than White British women to have a CMD (15.6%, compared with 20.9% respectively), while CMDs were more common in Black and Black British women

(29.3%). Perhaps because of small sample sizes, differences between ethnic groups in rates of specific disorders were not statistically significant. However, depression appeared to be more prevalent among Black women.

Disability
Overall, just over a quarter of adults (27.7%) reported having at least one of the five chronic physical conditions considered in this chapter diagnosed, and present in the last 12 months. High blood pressure was the most common, followed by asthma, diabetes, and cancer.

Other
Adults aged between 16 and 59 who lived alone were significantly more likely to have CMD than people who lived with others. Employed adults were less likely to have a CMD than those who were economically inactive or unemployed. Two-thirds of adults aged 16 to 64 in receipt of Employment and Support Allowance (ESA, a disability-related out-of-work benefit) had a CMD (66.1%), compared with one in six adults not in receipt of this benefit (16.9%). More than four in five women in receipt of ESA had a CMD (81.0%), compared with one in five (21.1%) of those not in receipt.

CMDs were more prevalent in certain groups of the population. These included Black women, adults under the age of 60 living alone, women living in large households, adults who were not in employment or who were in receipt of benefits and those who smoked cigarettes.

Common Mental Health Disorders data (PHE fingertips data, 2014/2015)

Indicator	Period	England
Estimated prevalence of common mental health disorders: % of population aged 16-74	2014/15	15.6*
Depression recorded prevalence (QOF): % of practice register aged 18+	2015/16	8.3
Depression recorded incidence (QOF): % of practice register aged 18+	2015/16	1.4
Long-term mental health problems (GP Patient Survey): % of respondents (aged 18+)	2015/16	5.2
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2015/16	12.7

*estimated

Liothyronine

The following evidence does indicate hypothyroidism is more prevalent which some of the protected characteristics (see below for details). The draft recommendations for liothyronine ensure that patients would be offered a suitable alternative. Where required this would involve an MDT of other health professionals. There are no recommendations that result in patients being disadvantaged by offering no alternative or one that was not agreed collaboratively by the patient and clinician

QOF prevalence for hypothyroidism (2013/2014) – 3.3%

Vanderpump MPJ. Braverman LE, Utiger RD. The epidemiology of thyroid diseases, Werner and Ingbar's The Thyroid: A Fundamental and Clinical Text , 2005, 9th edn, Philadelphia, JB Lippincott-Raven (pg. 398-496)

In iodine-replete communities, the prevalence of spontaneous hypothyroidism is between 1 and 2%, and it is more common in older women and 10 times more common in women than in men. Studies in Northern Europe, Japan and the USA have found the prevalence to range between 0.6 and 12 per 1000 women and between 1.3 and 4.0 per 1000 in men investigated. The prevalence is higher in surveys of the elderly in the community. Overt hypothyroidism was found in 7% of 558 subjects aged between 85 and 89 years in Leiden, Netherlands. A lower prevalence is seen in areas of iodine deficiency.

Flynn RV, MacDonald TM, Morris AD, et al. The thyroid epidemiology, audit and research study; thyroid dysfunction in the general population, J Clin Endocrinol Metab , 2004, vol. 89 (pg. 3879-84)

Data from the large population study in Tayside, UK has demonstrated that the standardized incidence of primary hypothyroidism varied between 3.90 and 4.89 per 1000 women per year between 1993 and 2001. The incidence of hypothyroidism in men significantly increased from 0.65 to 1.01 per 1000 per year (P = 0.0017). The mean age at diagnosis of primary hypothyroidism decreased in women from 1994 to 2001.

Hypertension (Doxazosin, Perindopril)
The following evidence does indicate hypertension is more prevalent which some of the protected characteristics (see below for details). The draft recommendations these drugs ensure that patients would be offered a suitable alternative. Where required this would involve an MDT of other health professionals. There are no recommendations that result in patients being disadvantaged by offering no alternative or one that was not agreed collaboratively by the patient and clinician

Knott C, Mindell J. Health Survey for England - 2011: Chapter 3, Hypertension. Leeds, UK: Health and Social Care Information Centre, 2012.

Age/sex
The relationship between age and the prevalence of hypertension differed between the sexes the prevalence of survey-defined hypertension was significantly higher in men than women across each age group apart from those aged 65 and over.

Deprivation
Mirroring the trends found with equivalised household income, the age-standardised prevalence of hypertension was highest among those living in areas of high deprivation. Prevalence rose from 26% of men and 23% of women in the least deprived quintile to 34% of men and 30% of women in the most deprived quintile.

2015/2016 QOF recorded prevalence for hypertension
The highest prevalence rates are for **Hypertension (13.8 per cent)**, Obesity (9.5 per cent) and Depression (8.3 per cent).

Hypertension (7.9 million), Obesity (4.3 million) and Depression (3.8 million) are the conditions reporting the highest register numbers.

National CVD Intelligence network (2014)
Estimated expected prevalence per total population = 23.6% (includes undiagnosed estimates)
NICE Equality Impact assessment for Hypertension CG34

NICE Equality Impact assessment for hypertension in pregnancy CG107

Appendix B

Patients prescribed Part A medicines, by gender

Prescriptions dispensed Jan - Dec 2016 *Source: NHS Business Services Authority*

	Number of patients			Percentage of patients		
	Female	Male	Total	Female	Male	Total
Hypertension	**53,939**	**79,726**	**133,665**	**40.4%**	**59.6%**	**100.0%**
Doxazosin MR	45,811	70,020	115,831	39.5%	60.5%	100.0%
Perindopril Arginine	8,128	9,706	17,834	45.6%	54.4%	100.0%
Mental Health	**93,183**	**34,458**	**127,641**	**73.0%**	**27.0%**	**100.0%**
Dosulepin	87,525	32,262	119,787	73.1%	26.9%	100.0%
Trimipramine Mal	5,658	2,196	7,854	72.0%	28.0%	100.0%
Pain	**388,707**	**203,092**	**591,799**	**65.7%**	**34.3%**	**100.0%**
Co-proxamol	5,591	2,153	7,744	72.2%	27.8%	100.0%
Fentanyl	3,834	2,571	6,405	59.9%	40.1%	100.0%
Lidocaine Plasters	50,396	21,767	72,163	69.8%	30.2%	100.0%
Oxycodone HCl/Naloxone HCl	7,612	4,112	11,724	64.9%	35.1%	100.0%
Rubefacients	302,161	163,411	465,572	64.9%	35.1%	100.0%
Tramadol HCl/Paracet	19,113	9,078	28,191	67.8%	32.2%	100.0%
Other	**29,013**	**59,175**	**88,188**	**32.9%**	**67.1%**	**100.0%**
Glucosamine and Chondroitin	1,273	703	1,976	64.4%	35.6%	100.0%
Herbal Medicines	2,021	1,002	3,023	66.9%	33.1%	100.0%
Homeopathic	1,541	899	2,440	63.2%	36.8%	100.0%
Liothyronine	11,432	1,628	13,060	87.5%	12.5%	100.0%
Lutein and Antioxidants	4,661	2,337	6,998	66.6%	33.4%	100.0%
Omega-3	8,042	20,118	28,160	28.6%	71.4%	100.0%
Tadalafil	43	32,488	32,531	0.1%	99.9%	100.0%
Grand Total	**564,842**	**376,451**	**941,293**	**60.0%**	**40.0%**	**100.0%**

Notes: Data for three patients omitted as no gender data available. Includes only prescriptions dispensed in the community

Patients prescribed Part A medicines, by age

Source: NHS Bu

Prescriptions dispensed Jan - Dec 2016

	Number of patients						Percentage of patients				
	Under 18	**18 to 30**	**31 to 44**	**45 to 64**	**65 and over**	**Total**	**Under 18**	**18 to 30**	**31 to 44**	**45 to 64**	**65 and over**
Hypertension	**8**	**377**	**3,763**	**41,132**	**88,385**	**133,665**	**0.0%**	**0.3%**	**2.8%**	**30.8%**	**66.1%**
Doxazosin MR	4	322	3,049	34,144	78,312	115,831	0.0%	0.3%	2.6%	29.5%	67.6%
Perindopril Arginine	4	55	714	6,988	10,073	17,834	0.0%	0.3%	4.0%	39.2%	56.5%
Mental Health	**68**	**2,547**	**10,142**	**47,554**	**67,330**	**127,641**	**0.1%**	**2.0%**	**7.9%**	**37.3%**	**52.7%**
Dosulepin	55	2,427	9,657	45,102	62,546	119,787	0.0%	2.0%	8.1%	37.7%	52.2%
Trimipramine Mal	13	120	485	2,452	4,784	7,854	0.2%	1.5%	6.2%	31.2%	60.9%
Pain	**7,966**	**18,849**	**52,722**	**170,877**	**341,388**	**591,802**	**1.3%**	**3.2%**	**8.9%**	**28.9%**	**57.7%**
Co-proxamol		11	144	1,658	5,931	7,744	0.0%	0.1%	1.9%	21.4%	76.6%
Fentanyl	52	422	1,141	2,581	2,209	6,405	0.8%	6.6%	17.8%	40.3%	34.5%
Lidocaine Plasters	450	2,523	8,634	25,522	35,034	72,163	0.6%	3.5%	12.0%	35.4%	48.5%
Oxycodone HCl/Naloxone HCl	8	365	1,418	4,620	5,313	11,724	0.1%	3.1%	12.1%	39.4%	45.3%
Rubefacients	7,369	14,356	38,316	127,268	278,266	465,575	1.6%	3.1%	8.2%	27.3%	59.8%
Tramadol HCl/Paracet	87	1,172	3,069	9,228	14,635	28,191	0.3%	4.2%	10.9%	32.7%	51.9%
Other	**976**	**1,454**	**5,893**	**25,871**	**25,834**	**60,028**	**1.6%**	**2.4%**	**9.8%**	**43.1%**	**43.0%**
Glucosamine and Chondroitin	2	12	34	571	1,357	1,976	0.1%	0.6%	1.7%	28.9%	68.7%
Herbal Medicines	584	145	261	689	1,344	3,023	19.3%	4.8%	8.6%	22.8%	44.5%
Homeopathic	359	273	386	635	787	2,440	14.7%	11.2%	15.8%	26.0%	32.3%

Liothyronine	28	511	2,705	6,872	2,944	13,060	0.2%	3.9%	20.7%	52.6%	22.5%
Lutein and Antioxidants			6	301	6,691	6,998	0.0%	0.0%	0.1%	4.3%	95.6%
Omega-3	73	346	1,924	12,803	13,014	28,160	0.3%	1.2%	6.8%	45.5%	46.2%
Tadalafil	3	513	2,501	16,803	12,711	32,531	0.0%	1.6%	7.7%	51.7%	39.1%
Grand Total	**9,091**	**23,573**	**74,444**	**298,237**	**535,951**	**941,296**	**1.0%**	**2.5%**	**7.9%**	**31.7%**	**56.9%**

Notes: Data for three patients omitted as no gender data available. Includes only prescriptions dispensed in the community