NHS England

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

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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 (for example 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 (for example NICE, MHRA). 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 once daily 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 two 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%). 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 5.8 for more details.

Looking at the age profiles of patients prescribed medications in 2016 (see 5.1) 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 such as chronic pain, hypertension and depression. The aim of this was to explore if there were indications that particular groups may be affected by the proposals 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.
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 displace 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.**

Consultation results

A 3 month consultation was undertaken from July – October 2017. This consultation provided an opportunity for views to be provided on the proposals for the 18 medicines and on the principle of restricting over the counter items. A full equality and health inequalities impact assessment will be undertaken for the policy development on over the counter (OTC) items. Appendix C includes an overview of key themes from the consultation for the 18 medicines. Key themes and results have also been reflected throughout the remainder of this document. The analysis undertaken as part of this equality and health inequalities impact assessment will be taken account of when considering the content of the final CCG guidance. It should be noted that the themes highlighted in appendix C should be considered within the wider context of the consultation results and report (see Items that should not be routinely prescribed in primary care consultation report, November 2017).

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:

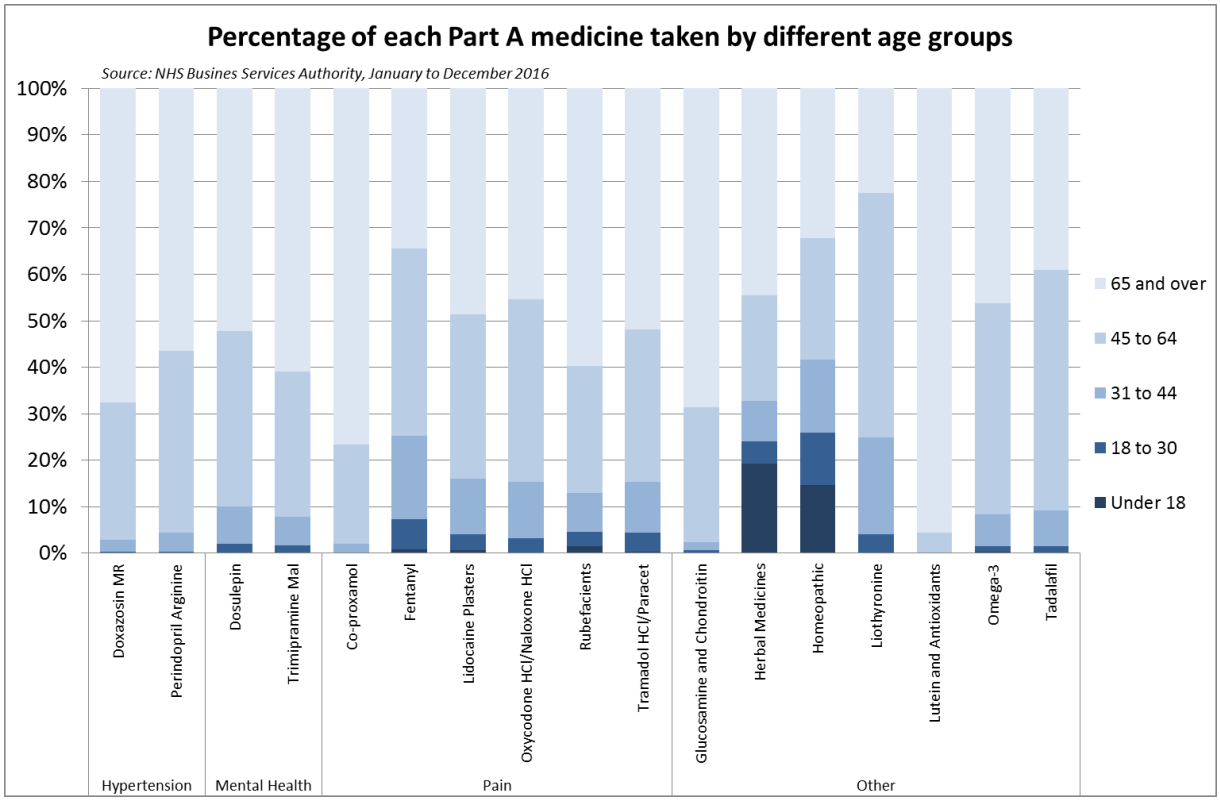
a) Does the equality group face discrimination in this work area?
b) Could the work tackle this discrimination and/or advance equality or good relations?
c) Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
d) Does any action need to be taken to address any important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

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 B 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).

During the consultation, responses were monitored to ascertain if there are any unintended consequences on this protected characteristic, see appendix C for results. The demographic analysis of the patients who responded to the online consultation showed that the patients from the older age groups, particularly disagreed with the proposals for herbal treatments and homeopathy. Age was also reported as a protected characteristic likely to be disproportionately affected by this

work by 56% of those responding to the question 'Do you feel there any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?'

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
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. It 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?
CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve.

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.

During the consultation, responses were monitored to ascertain if there are any unintended consequences on this protected characteristic, see appendix C for results. The demographic analysis of the patients who responded to the online consultation showed that the patients who reported having a disability particularly disagreed with the proposals for herbal treatments, homeopathy, immediate release fentanyl, lidocaine plasters, liothyronine, paracetamol and tramadol and travel vaccines. Disability was also reported as a protected characteristic likely to be disproportionately affected by this work by 63% of those responding to the question 'Do you feel there any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?' which was the highest reported protected characteristic for this question. A number of themes also emerged relating to disability including a concern that the proposal could adversely affect those who require considerable care (for example people with disabilities).

Could the work tackle this discrimination and/or advance equality or good relations?
This guidance, if adopted by CCGs, should prompt review of treatments meaning more people with a disability will receive reviews to optimise their treatment. It could assist in potentially reducing harm caused by certain medicines.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
There is the potential that it could assist in reducing harm caused by certain medicines if a person with a disability is more likely to receive them.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
Taking into account the consultation results and based on the clinical evidence, the CCG guidance has been updated to include a number of exceptions that take account of potential inequality e.g.

immediate release fentanyl for cancer and palliative care patients and liothyronine for patients with hypothyroidism, who, in exceptional circumstances, have an on-going need for liothyronine as confirmed by a consultant NHS endocrinologist.

CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve.

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.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the protected characteristic. There were no results from the consultation that indicated this.

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?
CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve.

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.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the protected characteristic. There were no results from the consultation that indicated this.

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?
CCGs will also be required to assess the impact of their population with regard to the particular

demographics of the population they serve.

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.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the protected characteristic. There were no results from the consultation that indicated this.

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?
CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve.

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.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the protected characteristic. There were no results from the consultation that indicated this.

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?
CCGs will also be required to assess the impact of their population with regard to the particular

demographics of the population they serve.

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.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the protected characteristic. There were no results from the consultation that indicated this.

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.

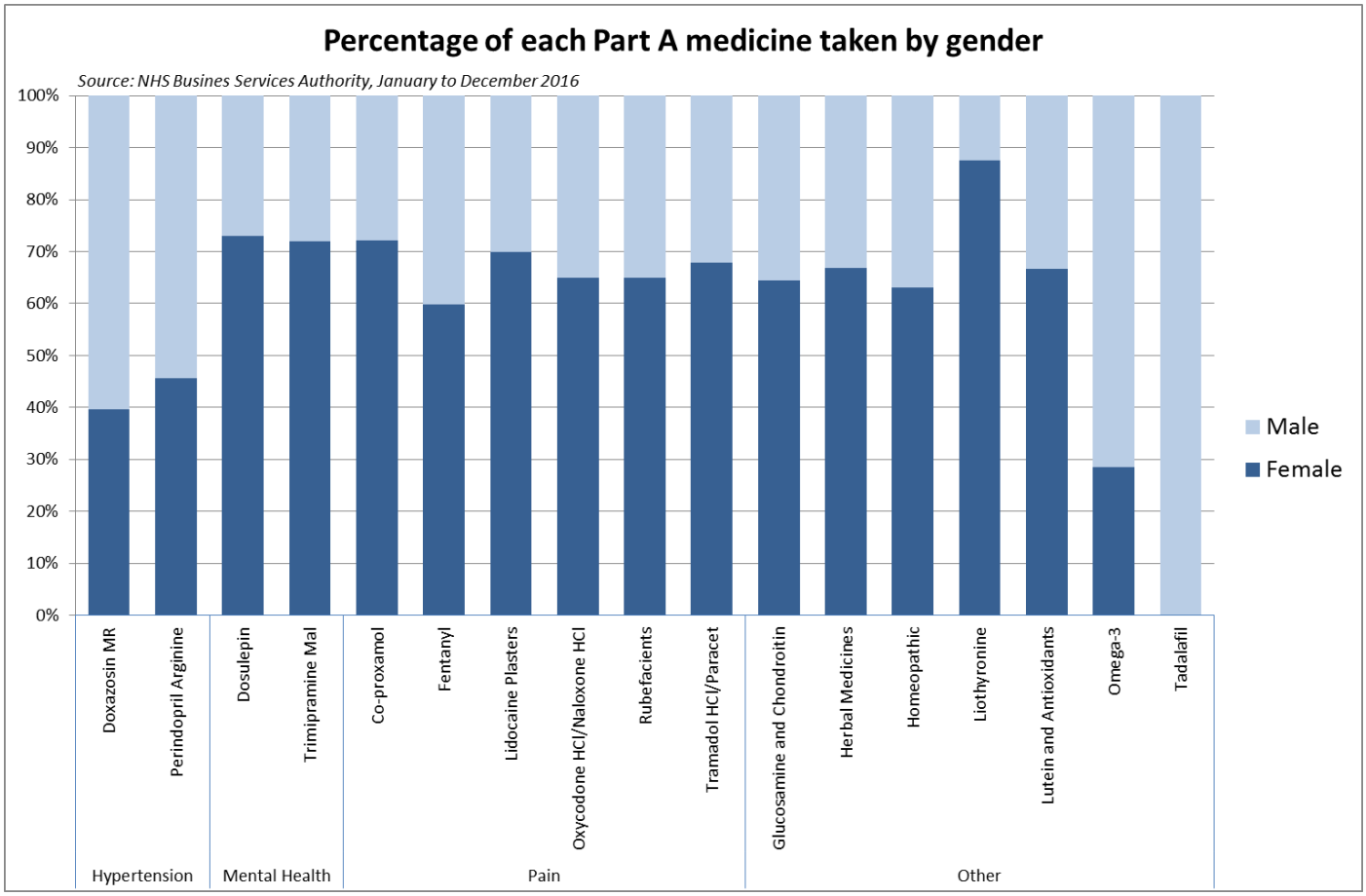
Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve

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 medicines 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, once daily tadalafil, 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.

During the consultation, responses were monitored to ascertain if there are any unintended consequences on this protected characteristic (see appendix C). The demographic analysis of the patients who responded to the online consultation showed that the female patients particularly disagreed with the proposals for liothyronine, herbal treatments and homeopathy. Gender was also reported as a protected characteristic likely to be disproportionately affected by this work by 31% of those responding to the question ‘Do you feel there any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?’. A key theme reported for liothyronine was that the removal of this drug would adversely affect many people, mainly women who are more prone to hypothyroidism.

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 (60%) are prescribed these medicines than males (40%). 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?
Taking into account the consultation results and based on the clinical evidence, the CCG guidance has been updated to include a number of exceptions for liothyronine.

CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve.

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.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the protected characteristic. There were no results from the consultation that indicated this.

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?
CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve.

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:

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

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. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

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. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.3. Carers

There is no data available on the prevalence of carers who are currently prescribed the medications in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

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. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.5. Those who have experienced Female Genital Mutilation (FGM)

There is no data available on the prevalence of those who have experienced Female Genital Mutilation (FGM) who are currently prescribed the medications in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

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.

The consultation received a response from the Friends and Families of Travellers highlighting that gypsy and traveller communities face the worse health, education and life outcomes of any group

within UK. They recommended implementing a system where doctors will only prescribe these medicines to people that really can't afford to pay for it as well as an awareness campaign aimed at this community. As this statement refers to medicines that are available OTC it is applicable to the items from the list of 18 that are also available OTC.

6.7. Homeless people and rough sleepers

There is no data available on the prevalence of homeless people and rough sleepers who are currently prescribed the medications in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

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. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

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.

There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.10.Sex workers

There is no data available on the prevalence of sex workers who are currently prescribed the medications in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

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. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

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.

There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

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

Have you have identified other groups that face inequalities in access to healthcare?

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.

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
- British Medical Association – General Practice Council
- Royal Pharmaceutical Society
- British Generic Manufactures Association (BGMA)
- Association British Pharmaceutical Industry (ABPI)
- PrescQIPP

Comments and suggestions were received on how to consult and reach further group

affected by the proposals.

A 3 month consultation was undertaken from July – October 2017. This consultation provided an opportunity for views to be provided on the proposals for the 18 medicines. As part of this consultation 5544 online responses and almost 200 written responses were received. A programme of engagement was also undertaken including webinars and engagement events with key stakeholder groups e.g. patients, professionals, CCGs, parliamentarians.

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 Business Services Authority, Royal College of GPs, Academy of Medical Royal Colleges, National Voices, Patients Association, Healthwatch England.

The consultation had involvement of a number of stakeholders and equalities and health inclusion groups (see Items that should not be routinely prescribed in primary care consultation report, November 2017).

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 are broadly supportive of the work on the proposals for the initial list of 18 items and concerns relating the equalities and health inequalities raised by stakeholders are reflected in appendix C and throughout this review.

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?

For some of the 18 items there are groups that are not broadly supportive of the specific recommendations. Further details can be found in appendix C and the ‘Items that should not be routinely prescribed in primary care consultation report (Nov 2017).

15. Further engagement and involvement activities planned.

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

Publication of the final CCG guidance on the 30 November, alongside the results from the

consultation.

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

Analysis, reporting and consideration of the prescribing data and consultation responses.

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.

Items that should not be routinely be prescribed in primary care consultation report (Nov 2017)

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. This 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 provided 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. This 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
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

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 definition. 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_UAhUFKVAKHTogBLMQFgglMAA&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 with 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 with 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 with 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

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

Appendix C

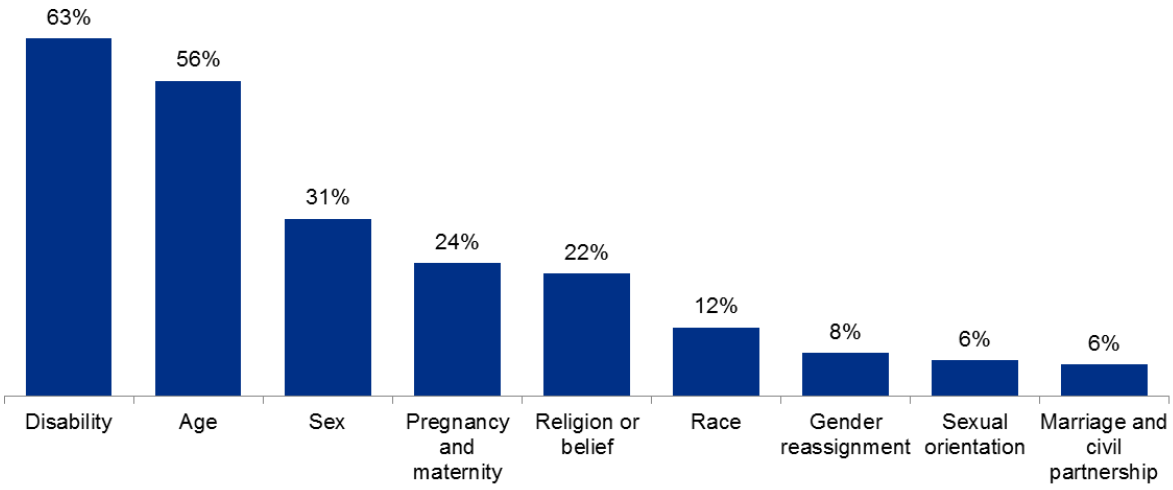
As part of the online consultation survey there were two questions that focused on the impact of the work on equalities and health inequalities as follows. Key results for these questions are also reported.

1. **Do you feel there any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?**

Table 1 – Responses to consultation question 'Do you feel there any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?' (n = 5541)

Response	Percentage
Yes	45%
No	33%
Prefer not to say	22%

Figure 1 – Responses to consultation question 'Which groups do you think will be effected' (n = 2230)



It should be noted that this questions related to the entirety of the project (i.e. 18 medicines review and the OTC item element) and so we cannot say with certainty which medicines figure 1 refers to. Although respondents were asked to provide further information on why they thought this might be the case, and the following relevant themes likely to relate to the 18 medicines emerged (other themes relating to OTC are picked up in the equalities and health inequalities impact assessment for this part of the project).

- The need for further communication/ assistance for BME communities and those with poor English.
- That the removal of liothyronine will adversely affect many people, mainly women who are more prone to hypothyroidism.
- That the proposal for herbal medicines would impact Chinese Community and users of herbal medication.

- That travel vaccines would have a greater uptake amongst BME groups who require vaccines when travelling to country of origin.
- This proposal adversely affects those who require considerable care (e.g. disabled, elderly).
- Proposal will make it harder for some to access treatment (e.g. elderly, disabled).
- Adversely affects those who cannot communicate their reliance on NHS-provided treatments, due to disability/age/computer literacy.

Themes that could relate to the 18 items that are also available OTC

- Adverse effects on living/impact ability to earn/ provide for family.
- Concerns some cohorts may not want to pay/be able to afford them (e.g. elderly, chronic illness) if they don't pay for them currently.

2. Do you feel there is any further evidence we should consider in our proposals on the potential impact on health inequalities experience by certain groups e.g. people on low incomes; people from BME communities?

Table 2 – Responses to consultation question 'Do you feel there is any further evidence we should consider in our proposals on the potential impact on health inequalities experience by certain groups' (n = 5407)

Response	Percentage
Yes	48%
No	29%
Unsure	23%

The relevant key themes reported from the further information for this question include:

- Consider the impact on patients with learning difficulties who won't understand the restrictions being placed on their medication.
- Consider effect on vulnerable groups and those who don't have the capacity to make their own decisions, those in care settings.
- Consider the implications on hypothyroid patients following the removal of treatments which have limited alternatives.
- Consider the quality of life for hypothyroid patients following removal of a key treatment.
- Concerns some medications may be less available/affordable in some areas (e.g. postcode lottery, rural area)*

*Applicable to some of the 18 medicines that are available OTC.

Some organisations, associations and societies responded to the consultation raising concerns about some form of discrimination for some or all of the groups mentioned in the Equality Act 2010. They were the Patients Association, National Association of Patient Participation (NAPP), Friends, Families and Travellers (FFT), Age UK, UK Health Prevention Forum, Leukaemia Care, Humanists UK, Thyroid UK, Royal Pharmaceutical Society, Royal Pharmaceutical Society, Pharmaceutical Services Negotiating Committee, Middlesex Pharmaceutical Group of Local Pharmaceutical

Committees, Dorset LPC, British Medical Association, National Pharmacy Association, Bayer, Pfizer UK, Dermal Laboratories Ltd, Company Chemists Association (CCA) and Association of the British Pharmaceutical Industry.

NICE did not feel that any groups, protected by the Equality Act 2010, were likely to be disproportionately affected by this work; nor does it feel that there is any further evidence NHS England should consider in their proposals on the potential impact on health inequalities experienced by certain groups.

The consultation also provided an opportunity for responders to say if they agreed or disagreed with the proposals for each of the 18 medicines and to provide further information. The following medicine specific themes relating to equalities and health inequalities were reported:

Doxazosin
- Consider impact on vulnerable groups.

Glucosamine and Chondroitin*
- Consider the impact on those on low income/ lower socioeconomic background and their ability to purchase the medication they, or their families need.

Homeopathy & herbal treatments*
- Consider the impact on those on low income/ lower socioeconomic background and their ability to purchase the medication they, or their families need.

IR Fentanyl
- Consider the effect on patients if this treatment is removed/limited (cancer, palliative care and patients with chronic pain specifically mentioned).

Lidocaine plasters
- May be implications for patients having to travel to hospital to collect their prescription.
- Restricting primary care prescribing of lidocaine plasters will significantly disadvantage pain and palliative care patients

Liothyronine
- Disproportionately impact low income households.
- The impact will be biased on age impacting patients who rely on pensions or young children who require parental income support.
- Withdrawal will breach obligations to patients with protected characteristics.
- That the removal of liothyronine will adversely affect many people, mainly women who are more prone to Hypothyroidism.

Lutein & antioxidants*
- Consider the impact on those on low income/ lower socioeconomic background and their ability to purchase the medication they, or their families need.

Omega-3 fatty Acid Compounds*
- Consider the impact on those on low income/lower socioeconomic background and their ability to purchase the medication they, or their families need

Travel Vaccines

- Consider impact on vulnerable groups (e.g. low income, high risk groups, BME, elderly)

*Available OTC

Although these themes relate to equalities and health inequalities, they should be considered in the context of the wider themes for the item (see consultation report, Nov 2017).

The demographic data from the consultation responses (based on the 9 protected characteristics) was also analysed for each of the proposals to see if there were any significant patterns of those who agreed/disagreed for each of the 18 items. The results showed that in general the only patient group to particularly disagree with proposals were, those patients considering themselves to have a disability. For certain medicines where females or older age groups were predominant users of the medicines, these groups were also identified to particularly disagree with the proposals.

Analysis by protected characteristic was performed for respondents identifying themselves as a patient. Patient groups were identified as particularly disagreeing with the proposal if the number of patients disagreeing was greater than those agreeing. Results were only included if total number either agreeing or disagreeing was greater than 50 (51 or over). If results were similar between groups of the same characteristic and in line with the overall response then result was not judged to be significant e.g. where patients in most age groups disagreed with the proposal.

Herbal treatments

Patients from older age groups, female patients and those considering themselves to have a disability particularly disagreed with the proposals:

Herbal Treatments

		Age groups				
Proposal	**Response**	**50-59**	**60-69**	**70-79**	**Females**	**Disability**
Advise CCGs that prescribers in primary care should not initiate herbal items for any new patient.	Agree	27	22	6	66	54
	Disagree	104	109	41	282	62
	Neither agree or disagree	0	1	0	3	2
	Unsure	0	0	0	4	4
	Percent disagree	**79%**	**83%**	**87%**	**79%**	**51%**
Advise CCGs to support prescribers in deprescribing herbal items in all patients and where appropriate, ensure the availability of relevant services to facilitate this change.	Agree	47	29	14	112	60
	Disagree	80	98	31	228	110
	Neither agree or disagree	1	2	1	4	0
	Unsure	2	3	1	10	3
	Percent disagree	**62%**	**74%**	**66%**	**64%**	**64%**

Homeopathic items

Patients from older age groups, female patients and those considering themselves to have a disability particularly disagreed with the proposals.

Homeopathic items

		Age groups					
Proposal	**Response**	**40-49**	**50-59**	**60-69**	**70-79**	**Female**	**Disability**
Advise CCGs that prescribers in primary care should not initiate homeopathic items for any new patient.	Agree	54	54	37	10	100	60
	Disagree	104	155	174	68	445	110
	Neither agree or disagree	0	0	1	1	0	0
	Unsure	2	1	1	0	4	3
	Percent disagree	**65%**	**74%**	**82%**	**86%**	**81%**	**64%**
Advise CCGs to support prescribers in deprescribing homeopathic items in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.	Agree	72	87	54	14	175	79
	Disagree	83	119	156	61	367	85
	Neither agree or disagree	3	3	2	3	5	6
	Unsure	2	1	0	0	2	2
	Percent disagree	**52%**	**57%**	**74%**	**78%**	**67%**	**49%**

IR Fentanyl

Patients considering themselves to have a disability particularly disagreed with the proposals. Whilst the total number responding was less than 50 the results are nonetheless included here as the number of people with a disability made up a significant proportion of all those responding to the questions for this medicine.

IR Fentanyl

Patients considering themselves to have a disability

Response	Advise CCGs that prescribers in primary care should not initiate Immediate Release Fentanyl for any new patient.	Advise CCGs to support prescribers in deprescribing Immediate Release Fentanyl in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
Agree	6	9
Disagree	20	19
Neither agree or disagree	4	2
Unsure	0	0
Percent disgaree	**67%**	**63%**

Lidocaine plasters

Patients considering themselves to have a disability particularly disagreed with the proposals.

Lidocaine Plasters

Patients considering themselves to have a disability

Response	Advise CCGs that prescribers in primary care should not initiate Lidocaine plasters for any new patient.	Advise CCGs to support prescribers in deprescribing lidocaine plasters in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
Agree	7	17
Disagree	57	50
Neither agree or disagree	5	1
Unsure	2	3
Percent disgaree	80%	70%

Liothyronine

Female patients and those considering themselves to have a disability particularly disagreed with the proposals.

Liothyronine

Proposal	Response	Female	Disability
Advise CCGs that prescribers in primary care should not initiate Liothyronine for any new patient.	Agree	20	11
	Disagree	1025	385
	Neither agree or disagree	17	8
	Unsure	8	2
	Percent disagree	**96%**	**95%**
Advise CCGs to support prescribers in deprescribing Liothyronine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.	Agree	201	79
	Disagree	843	318
	Neither agree or disagree	16	5
	Unsure	9	3
	Percent disagree	**79%**	**79%**

Omega-3 Fatty Acids

Female patients particularly disagreed with the proposal to not initiate medicine for new patients

Omega-3 Fatty Acids

Female patients

	Advise CCGs that prescribers in primary care should not initiate Omega-3 Fatty Acids for any new patient.	**Advise CCGs to support prescribers in deprescribing Omega-3 Fatty acids in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.**
Agree	28	35
Disagree	40	33
Neither agree or disagree	2	3
Unsure	1	1
Percent disagree	56%	46%

Paracetamol and Tramadol

Patients considering themselves to have a disability particularly disagreed with the proposal to advise CCGs not to initiate combination product for new patients

Paracetamol and Tramadol
Patients considering themselves to have a disability

	Advise CCGs that prescribers in primary care should not initiate Paracetamol and Tramadol combination product for any new patient.
Agree	28
Disagree	46
Neither agree or disagree	3
Unsure	3
Percent disagree	58%

Travel vaccines

Patients considering themselves to have a disability particularly disagreed with the proposal

Travel vaccines
Patients considering themselves to have a disability

	Advise CCGs that prescribers in primary care should not initiate the stated travel vaccines for any new patient.
Agree	27
Disagree	59
Neither agree or disagree	1
Unsure	2
Percent disagree	66%