Equality and Health Inequalities – Full Analysis - Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs

NHS England and NHS Improvement

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PART A: General Information

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

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. This guidance updates original CCG guidance published in November 2017 for one item only (rubefacients) and includes recommendations for 8 further items which have not previously been included in guidance.

Recommendations 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; and/or
- Items which are clinically effective but due to the nature of the product, are deemed a low priority for NHS funding.

An equality and health inequalities – full analysis is also available for the original 18 items which can be accessed here.

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

- Staff – primarily primary care prescribers (e.g. GPs) who prescribe items identified within the commissioning guidance. Other staff groups (e.g. community pharmacy staff, secondary care clinicians) will also be impacted and will have a role to support patients in changes to their therapies.
- Patients – those 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?

The nine 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. The profile of people who are currently being prescribed each item can only be interrogated accurately for age and gender as national prescribing data available from the NHS Business Services Authority (NHS BSA) is only available for these two characteristics. We are therefore only able to demonstrate an accurate patient profile for individual items for these two characteristics. However, we have also used data and responses collected from this consultation to further inform development of the final guidance.

Overall this prescribing data for 2017/18 indicates that all items in the review are prescribed almost equally for males and females.

Looking at the age profiles of patients prescribed medications in 2017/18 (see 5.1) the items prescribed for cardiovascular conditions and diabetes are more commonly prescribed in patients over the age of 65 years. Bath and shower emollient preparations and silk garments were prescribed most frequently to under 18 year olds, although bath and shower emollient preparations were prescribed in an almost equal proportion to the over 65 year age group.

A literature review was also undertaken to explore the research evidence on patient characteristics within disease areas rather than by individual item. The aim of this exercise was to explore whether particular groups of patients may be affected by the proposals in a more general sense. Full results can be seen in Appendix A. Overall the evidence reflects patterns seen in the prescribing data with no additional indication that specific groups of the population would be adversely impacted by the recommendations.

Some of the items 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 items which are shown to be of low clinical effectiveness. 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 November 2018 – February 2019. This consultation provided an opportunity for views to be provided on the proposals for the update to the recommendations on rubefacients and the 8 new items. Appendix C includes an overview of key themes from the consultation for the 1 update and 8 new items proposed for inclusion in the updated CCG guidance. Relevant 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 was 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 which should not routinely be prescribed in primary care consultation report, June 2019).

All consultation results were considered and the clinical working group felt there were no changes required to the proposals to mitigate risk of inequality, although some changes were made to the proposed guidance following the consultation and these are detailed in the final CCG guidance.

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?

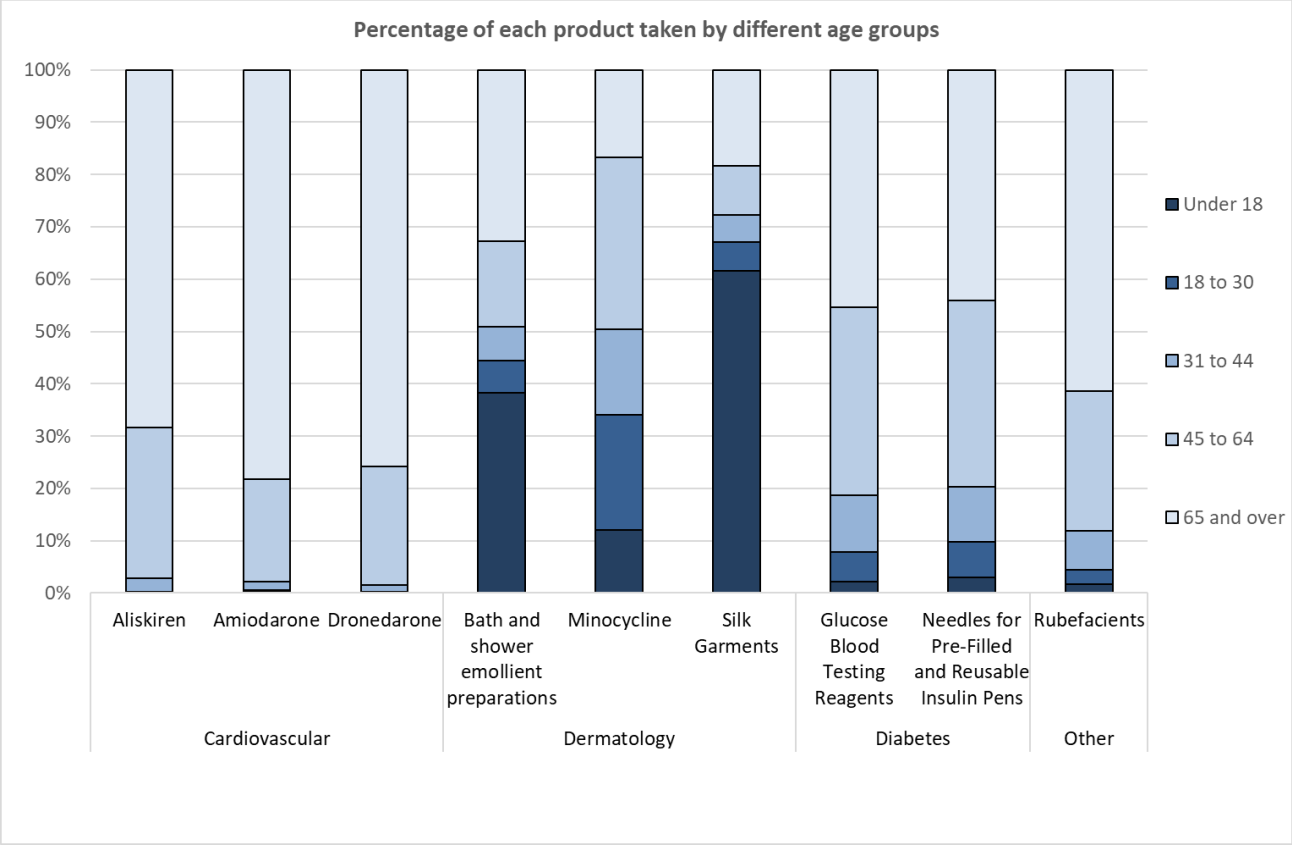
e) If you cannot answer these questions what action will be taken and when?

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 2017/18 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 items in 2017/18, the items related to cardiovascular issues, diabetes and the rubefacients were most frequently prescribed to adults aged 45 and over. For the cardiovascular medications, in over 65% of cases, they were prescribed to the 65 year and over age group and no patients aged 30 or lower were prescribed these items.

Bath and shower preparations were prescribed most frequently to the under 18 year old (38%) and the 65 and over age groups (33%). Silk garments were prescribed most frequently to the under 18 year old group (62%). Minocycline prescriptions were also prescribed in an even distribution across all age bands.

As people of increasing age take more prescribed medicines, older people are likely to receive more items included within our proposed guidance on *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 these patients' treatments to optimise their treatment with more effective medicines.

During the consultation, responses were monitored to ascertain if there are any unintended consequences on this protected characteristic, see appendix C for results. For those who responded to the online consultation, the demographic analysis of patient age, didn't show a particular difference or stronger view between age groups, with regards to agreeing or disagreeing with the recommendations

When looking at the themes for individual items from the consultation, the following themes relating to age were reported by respondents:

- Elderly patients who are more likely to be prescribed amiodarone and dronedarone.
- Impact of the recommendations for bath and shower preparations for dry and pruritic skin conditions on children with eczema.
- Bath and shower preparations for dry and pruritic skin conditions – consider impact on vulnerable age groups (e.g. young children and the elderly).

There was no indication from the wider consultation results that the proposals would result in people of particular ages experiencing inequalities in access to healthcare or health outcomes.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused to patients by certain prescribed items which older and younger people are more likely to receive. The recommendations for bath and shower preparations recommend an alternative product where appropriate.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
During the 3 month consultation, communications and engagement activities were undertaken with specific patient groups and charities to ensure that people of age groups who may be more widely represented were adequately able to respond to the consultation. During the consultation, responses were monitored to ascertain if there were 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. We expect CCGs to take the proposed guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties.

CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

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.

During the consultation, responses were monitored to ascertain if there are any unintended consequences on this protected characteristic, see appendix C for results. For those who responded to the online consultation, a higher proportion of patients who reported having a disability disagreed with our recommendations for specific items, compared to those who did not have a disability. These items included: Bath and shower preparations for dry and pruritic skin conditions, blood glucose testing strips, dronedarone, needles for pre-filled insulin pens and rubefacients.

There was no indication from the wider consultation results that the proposals would result in people with disabilities experiencing inequalities in access to healthcare or health outcomes.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews 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)?
These medication reviews could assist in potentially reducing harm caused to patients by certain medicines (not necessarily included in this guidance) which people with a disability 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 the 3 month consultation communications and engagement activities were undertaken with specific patient groups and charities to ensure that people with and without disabilities, were adequately able to respond to the consultation.

CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve. We expect CCGs to take the guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties. CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

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.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people who have undergone gender reassignment.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused to patients by certain prescribed items which people who have undergone gender reassignment 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 the 3 month consultation communications and engagement activities were undertaken with specific patient groups and charities to ensure that people with this protected characteristic, were adequately able to respond to the consultation.

CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve. We expect CCGs to take the guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties. CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

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?
Medication reviews could be used as an opportunity to optimise medical treatment for people who are married or in a civil partnership.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused to patients by certain prescribed items which people who are married or in a civil partnership 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 the 3 month consultation, communications and engagement activities were undertaken with specific patient groups and charities to ensure that people with this protected characteristic, were adequately able to respond to the consultation.

CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve. We expect CCGs to take the guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties. CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

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 who are pregnant or who have had a baby will be affected.

None of the items proposed in the guidance are used for conditions that are closely related to pregnancy or maternity. We expect prescribers will use medications *Summary of Product Characteristics* to inform treatment if any of these medicines are going to be used and prescribe accordingly.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people who are pregnant or who have had a baby.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused to patients by certain prescribed items which people who are pregnant or who have had a baby 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 the 3 month consultation, communications and engagement activities were undertaken with specific patient groups and charities to ensure that people with this protected characteristic, were adequately able to respond to the consultation.

CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve. We expect CCGs to take the guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties. CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

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. Although there is an indication that the prevalence of type 2 diabetes is more prevalent for particular ethnic groups, the draft recommendation for these items is that a prescriber should offer a more cost-effective substitution rather than deprescribe.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people of all races.

During the consultation, responses were monitored to ascertain if there are any unintended consequences on this protected characteristic, see appendix C for results. For those who responded to the online consultation, the demographic analysis of race for those who had reported this, didn't show a particular difference or stronger view between different races.

When looking at the themes for individual items from the consultation, the following themes relating to race were reported by respondents:

- Need to consider the impact on groups with increased prevalence of diabetes (e.g. ethnic minorities).

- Bath and shower preparations - proposal will disproportionately affect ethnic minorities.

There was no indication from the wider consultation results that the proposals would result in any particular race experiencing inequalities in access to healthcare or health outcomes.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused by prescribed items to patients of all races.

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

During the 3 month consultation, communications and engagement activities were undertaken with specific patient groups and charities to ensure that people of all races, were adequately able to respond to the consultation.

CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve. We expect CCGs to take the guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties. CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

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 belief so we cannot definitively assess, at a national level, how many people will be affected. We have not identified any religious belief that would make a patient 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?
Medication reviews could be used as an opportunity to optimise medical treatment for people of all religious beliefs.

During the consultation, responses were monitored to ascertain if there are any unintended consequences on this protected characteristic, see appendix C for results. For those who responded to the online consultation, the demographic analysis of religion and belief for those who had reported this, didn't show a particular difference or stronger view between those with different relions of beliefs.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused by prescribed items to patients of all religious beliefs.

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

During the 3 month consultation, communications and engagement activities were undertaken with specific patient groups and charities to ensure that people of all religions and beliefs, were adequately able to respond to the consultation.

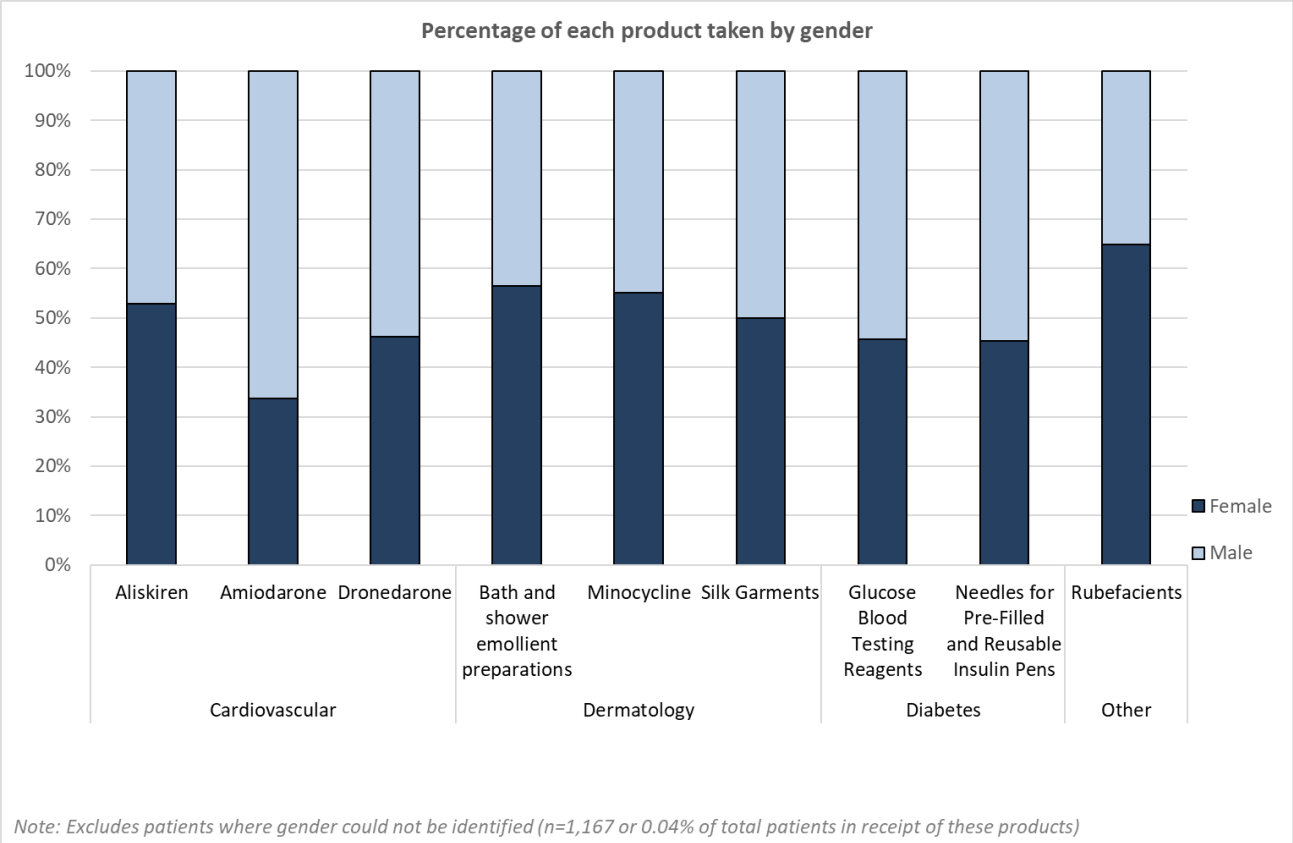
CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve. We expect CCGs to take the guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties. CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

5.8. Sex or gender

Does the equality group face discrimination in this work area?
Nationally approximately 43% of men and 50% of women take at least one prescribed medicine. This proportion is higher among young women than young men, but increases more sharply with age in men than women. Overall 22% of men and 24% of women report that they take at least three prescribed medicines; although this proportion increases 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 2017/18 by gender (see appendix B for source data)



Note: Excludes patients where gender could not be identified (n=1,167 or 0.04% of total patients in receipt of these products)

Could the work tackle this discrimination and/or advance equality or good relations?
Overall this prescribing data for 2017/18 indicates approximately the same amount of females (50.4%) and males (49.6%) were prescribed the items. This indicates that medication reviews and potential deprescribing may be required equally for males and females.

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)?
During the consultation, responses were monitored to ascertain if there are any unintended consequences on this protected characteristic, see appendix C for results. For those who responded to the online consultation, the demographic analysis for those who had reported their gender didn't show a particular difference or stronger view between different genders.

When looking at the themes for individual items from the consultation, the following themes relating to gender were reported by respondents:

- Blood glucose testing strips - proposal will affect women more than men.

There was no indication from the wider consultation results that the proposals would result in any particular gender experiencing inequalities in access to healthcare or health outcomes. There is the potential that it could assist in potentially reducing harm caused by certain prescribed items 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 the 3 month consultation, communications and engagement activities were undertaken with specific patient groups and charities to ensure that people of all genders, were adequately able to respond to the consultation.

CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve. We expect CCGs to take the guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties. CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

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 the prescribing of items proposed in this guidance and sexual orientation.

Could the work tackle this discrimination and/or advance equality or good relations?
Medication reviews could be used as an opportunity to optimise medical treatment for people of all sexual orientations.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
This work could assist in potentially reducing harm caused by prescribed items to patients of all sexual orientations.

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

During the 3 month consultation, communications and engagement activities were undertaken with specific patient groups and charities to ensure that people of all sexual orientations, were adequately able to respond to the consultation.

CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve. We expect CCGs to take the guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice.

The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties. CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

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 items in the review are specifically used to support the treatment of patients suffering alcohol or drug misuse. There is no data available on the prevalence of alcohol or drug users who are currently prescribed the items 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 items 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 items in the review. There was a theme from the consultation highlighting the need to consider the impact on carers in managing treatment. 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 items in the review. There was no indication from the consultation results that the

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

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 items 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 items 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.

6.7. Homeless people and rough sleepers

There is no data available on the prevalence of homeless people and rough sleepers who are currently prescribed the items 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 items 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

None of the medicines in the review are specifically used in the treatment of mental health conditions. There is no data available on the prevalence of people with mental health conditions who are currently prescribed the items 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.

6.10.Sex workers

There is no data available on the prevalence of sex workers who are currently prescribed the items 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 items 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 items 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?
No other groups have not been identified from the consultation responses.

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 may be 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.

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

N/A

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.

N/A

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 clinical working group in partnership with NHS Clinical Commissioners with membership from their own organisations plus partner organisations. During November 2018 stakeholder engagement was undertaken with national patient organisations to contribute their views on the proposals including:

- National Voices
- Healthwatch
- Patient Association

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

A 3 month public consultation was undertaken from November 2018 – February 2019. This consultation provided an opportunity for views to be provided on the proposals for the 1 updated item and 8 new items. As part of this consultation 1461 online responses and almost 54 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 etc.

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

NHS England, NHS Clinical Commissioners, Royal Pharmaceutical Society, NICE, Department of Health and Social Care, PrescQIPP, NHS Business Services Authority, Royal College of GPs, National Voices, Patients Association, Healthwatch.

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, June 2019).

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 1 updated and 8 new items. Results and themes relating to equalities and health inequalities raised by stakeholders are reflected in appendix C and throughout this review. Full consultation results as outlined in the report 'Items that should not be routinely prescribed in primary care consultation report' (June 2019).

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 additional items in the update guidance there are groups that are not broadly supportive of the recommendations. Further details can be found in appendix C and the 'Items that should not be routinely prescribed in primary care consultation report (June 2019).

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 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

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 items.

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) community pharmacy reimbursement data 2017/18.

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 (June 2019).

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 of 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. We expect CCGs to take the guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties. CCGs still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

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 prescribed items that are unsafe, ineffective or where there is a more cost effective alternative available. By setting a national direction on a set of defined items, this project encourages CCGs to implement policy that encourages review of patients taking these items to ensure that their treatment is optimised, it can also reduce variation across the country. This enables patients to have access to the most effective products 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 Priority Prescribing clinical 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 prescribed items that are unsafe, ineffective or where there is a more cost effective alternative available. By setting a national direction on a set of defined items this project encourages CCGs to implement policy that encourages review of patients taking these items to ensure that their treatment is optimised. This enables patients to have access to the most effective products 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 items will benefit. If CCGs implement the guidance once finalised, all patients being prescribed the included items should be considered for medication reviews aimed 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 from the national consultation when making individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities. 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	Yes	Yes	Post guidance publication	CCGs

that local implementation decisions are effective and in line with legislation.				
Support implementation with resources referenced in the guidance to support prescribers with deprescribing and offer of alternative prescribed items where appropriate.	Yes	Yes	Post guidance publication	Project team

Appendix A

Equalities and Health Inequalities Evidence Search

Cardiovascular conditions

The following evidence indicates that cardiovascular conditions such as hypertension are more prevalent with some of the protected characteristics (see below for details). The draft recommendations for 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.

Prevalence
2015/2016 QOF recorded prevalence for hypertension Report hypertension prevalence rate as 13.8 per cent.

National CVD Intelligence network (2014) estimate expected prevalence per total population = 23.6% (includes undiagnosed estimates).

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

Dermatology

The following evidence does indicate that eczema is more prevalent depending on age. Atopic eczema affects more children than adults, this is estimated at 15 - 20% of children and 1 - 3% of adults worldwide.
Asher MI, Montefort S, Bjorksten B, Lai CK, Strachan DP, Weiland SK, Williams H: Worldwide time trends in the prevalence of symptoms of asthma, allergic rhinoconjunctivitis, and eczema in childhood: ISAAC Phases One and Three repeat multicountry cross-sectional surveys. Lancet 2006;368:733-743.

The following evidence from the Global Burden of Disease Project estimates the prevalence of acne at 9.4%. Studies evaluating sex differences have shown that acne is more prevalent in girls at younger age ranges, with increasing prevalence in boys as they reach puberty. Following the teenage years, the prevalence in women again tends to be higher than in men.
https://onlinelibrary.wiley.com/doi/full/10.1111/bjd.13462

Type 2 Diabetes

Public Health England data indicates that the prevalence of diabetes in England is 6.7% (QOF, 2016/17). The highest percentage of people with type 2 diabetes are aged between 40 – 79 years. Data indicates that type 2 diabetes is slightly more prevalent in males than females.
https://fingertips.phe.org.uk/profile/diabetes-ft/data#page/0/gid/1938133138/pat/46/par/E39000030/ati/153/are/E38000010

Type 2 diabetes is much more common in ethnic minorities groups residing in developed countries; South Asian and African-Caribbean groups in the UK in particular have a high prevalence. Poverty has also been recognised as a contributor to prevalence of type 2 diabetes.
Riste L, Khan F, Cruickshank K. High prevalence of type 2 diabetes in all ethnic groups, including Europeans, in a British inner city: relative poverty, history, inactivity, or 21st century Europe? Diabetes Care2001;24:1377–83.

Chronic pain conditions – rubefacients

The following evidence indicates that the prevalence of chronic pain increases with age and was higher among females, and in people with disabilities, low incomes and low educational levels. 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 rubefacients ensure that patients would be offered a suitable alternative and where required, this would involve other relevant services. Recommendations do not result in patients being disadvantaged by offering no pain relief or an alternative that was not agreed collaboratively by the patient and clinician.

The estimated prevalence of chronic pain in the UK, 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.
Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies (Fayaz, 2016)

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, 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.

Appendix B

Patients prescribed products by gender

(April 2017 - March 2018) *Source: NHS Business Services Authority*

	Number of identifiable patients				Percentage of identifiable patients			
	Female	**Male**	**Unknown**	**Total**	**Female**	**Male**	**Unknown**	**Total**
Aliskiren	1,410	1,253		**2,663**	52.9%	47.1%	0.0%	**100.0%**
Amiodarone	19,867	39,081	9	**58,957**	33.7%	66.3%	0.0%	**100.0%**
Bath and shower emollient preparations	486,695	374,071	792	**861,558**	56.5%	43.4%	0.1%	**100.0%**
Dronedarone	1,277	1,482		**2,759**	46.3%	53.7%	0.0%	**100.0%**
Glucose Blood Testing Reagents	568,143	673,188	204	**1,241,535**	45.8%	54.2%	0.0%	**100.0%**
Minocycline	5,385	4,399	7	**9,791**	55.0%	44.9%	0.1%	**100.0%**
Needles for Pre-Filled and Reusable Insulin Pens	297,006	357,465	80	**654,551**	45.4%	54.6%	0.0%	**100.0%**
Rubefacients	207,819	112,279	138	**320,236**	64.9%	35.1%	0.0%	**100.0%**
Silk Garments	3,752	3,745	6	**7,503**	50.0%	49.9%	0.1%	**100.0%**
Total	**1,591,354**	**1,566,963**	**1,236**	**3,159,553**	**50.4%**	**49.6%**	**0.0%**	**100.0%**

Notes: Patient counts are not unique across products. A patient is counted once per product but if they are prescribed multiple products then they will be counted multiple times. Patient gender will be unknown where the information could not be identified via the Personal Demographics Service (PDS) for an individual patient

Patients prescribed products by age band

(April 2017 - March 2018) *Source: NHS Business Services Authority*

	Number of identifiable patients						Percentage of identifiable 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**	**Total**
Aliskiren		6	69	769	1,819	**2,663**	0.0%	0.2%	2.6%	28.9%	68.3%	**100.0%**
Amiodarone	135	197	907	11,547	46,171	**58,957**	0.2%	0.3%	1.5%	19.6%	78.3%	**100.0%**
Bath and shower emollient preparations	329,075	53,774	55,852	140,075	282,782	**861,558**	38.2%	6.2%	6.5%	16.3%	32.8%	**100.0%**
Dronedarone		5	39	622	2,093	**2,759**	0.0%	0.2%	1.4%	22.5%	75.9%	**100.0%**
Glucose Blood Testing Reagents	28,000	69,659	135,318	446,059	562,499	**1,241,535**	2.3%	5.6%	10.9%	35.9%	45.3%	**100.0%**
Minocycline	1,182	2,155	1,606	3,217	1,631	**9,791**	12.1%	22.0%	16.4%	32.9%	16.7%	**100.0%**
Needles for Pre-Filled and Reusable Insulin Pens	19,429	44,816	68,549	233,218	288,539	**654,551**	3.0%	6.8%	10.5%	35.6%	44.1%	**100.0%**
Rubefacients	5,386	8,688	24,233	85,418	196,511	**320,236**	1.7%	2.7%	7.6%	26.7%	61.4%	**100.0%**
Silk Garments	4,620	413	395	697	1,378	**7,503**	61.6%	5.5%	5.3%	9.3%	18.4%	**100.0%**
Total	**387,827**	**179,713**	**286,968**	**921,622**	**1,383,423**	**3,159,553**	**12.3%**	**5.7%**	**9.1%**	**29.2%**	**43.8%**	**100.0%**

Notes: Patient counts are not unique across products. A patient is counted once per product but if they are prescribed multiple products then they will be counted multiple times. The patients age is based on the maximum age of the patient, at the time of prescribing, during the financial year. Therefore a single patient will only appear in the results for one age group for a particular drug category

Appendix C

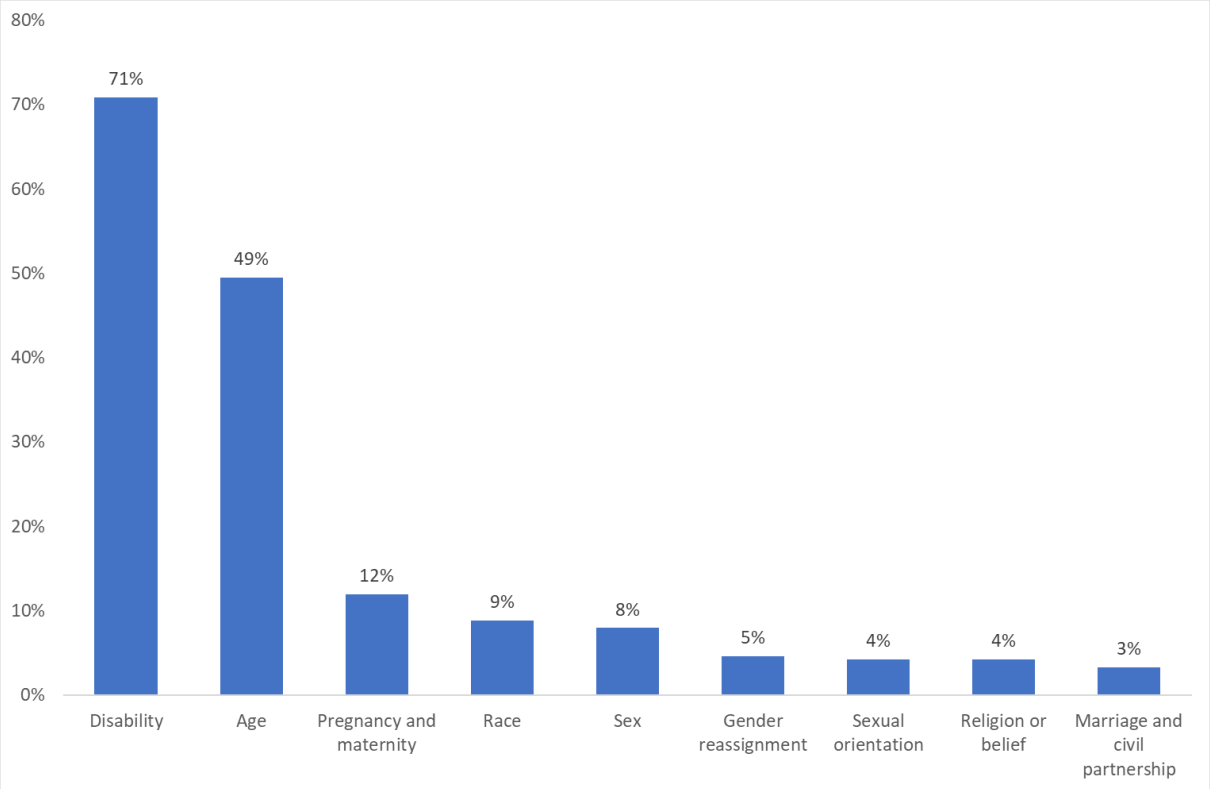
As part of the online consultation survey there were two questions that focused on the impact of the work on equalities and health inequalities as follows. Key results for these questions are also reported.

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 = 1,461)

Response	Percentage
Yes	31%
No	41%
Unsure	28%

Figure 1 – Responses to consultation question 'Which groups do you think will be effected' (n = 453)



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 = 1,434)

Response	Percentage
Yes	34%
No	39%
Unsure	26%

Themes relating to equalities and health inequalities reported from the further information. It should be noted that the themes highlighted here should be considered within the wider context of the consultation results and report (see Items which should not routinely be prescribed in primary care consultation report, June 2019). The following themes were reported:

- Adversely affects those who require considerable care (e.g. disabled, elderly).
- Impact on those on low income/lower socioeconomic background.
- Make it harder for some to access treatment or medication.
- Impact on children with eczema.
- Adversely affect patients with diabetes.
- Need to consider the impact on groups with increased prevalence of diabetes (e.g. ethnic minorities).
- Need to consider the requirements of patients with rare illnesses.
- Need to consider the impact on carers in managing treatment.
- CCGs should be seeking the most cost-effective medications for all.

The consultation also provided an opportunity for respondents to say if they agreed or disagreed with the proposals for each of the updated and new items and to provide further information. It should be noted that the themes highlighted here should be considered within the wider context of the consultation results and report (see Items which should not routinely be prescribed in primary care consultation report, June 2019). The following item specific themes relating to equalities and health inequalities were reported:

Aliskiren

- Consider that deprescribing of aliskiren may not be straight forward in some patient groups.

Amiodarone

- Consider the impact on elderly patients who are more likely to be prescribed amiodarone and dronedarone.
- Consider the impact on vulnerable groups (e.g. high risk groups, BME, elderly).

Bath and shower preparations for dry and pruritic skin conditions

- Consider the impact on children with eczema.
- Consider the impact on vulnerable age groups (e.g. young children and the elderly).
- Consider the impact on those on low income / lower socioeconomic background.
- The proposal should consider exempting specific groups of people (e.g. children, those with genital dermatoses or hand dermatitis).
- Proposal will disproportionately affect ethnic minorities.

Blood glucose testing strips for type 2 diabetes

- Consider that effective blood glucose testing prevents adverse patient outcomes
- Proposal could restrict access to insulin pen needles and blood glucose testing strips for patients with type 1 diabetes
- Type 2 insulin-dependent diabetics should be treated the same as type 1 insulin-dependent diabetics
- Consider impact on vulnerable groups (e.g. low income, high risk groups, BME, elderly, pregnant patients, children).
- Proposal will affect women more than men.
- The proposal should consider that some groups of patients will require more expensive testing strips

Needles for pre-filled and reusable insulin pens

- Proposal disproportionately affects certain groups (e.g. disabled people, women, ethnic minorities)
- Proposal limits the accessibility of safety needles which are needed for specific groups of people (e.g. needle phobic, visual disability)
- Consider the impact on diabetes patients with poor dexterity
- Children should be exempt from the proposal

Silk garments

- Consider the impact of accessibility to silk garments on patient outcomes
- Consider impact on vulnerable groups (e.g. high-risk groups, BME, elderly, pregnant patients)
- The proposal should consider exempting specific groups of people (e.g. severe cases, chronic conditions)
- Consider the impact on those on low income / lower socioeconomic background

Rubefacients

- Consider the impact on those with low incomes and their ability to purchase rubefacients

Analysis of responses from patients, by protected characteristics

Responses from the 673 patients[2] were analysed by the protected characteristics captured in the online survey. Where a patient group responded with a particularly different or stronger view to other patients within the same protected characteristic then this is reported here. That does not however mean that patients with other protected characteristics do not disagree with the proposals. Where patients overall disagree with proposals then it will be the case that this will be reflected across the

[2] In the survey 667 respondents ticked the box that identified them as a patient but six other respondents identified themselves as a patient in the free text box so these were recoded as patients in the dataset.

patient characteristics unless noted here. For example, only where males and females disagree to a different extent with a proposal will this be reported here.

Bath and shower preparations for dry and pruritic skin conditions

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

		Disability	
Proposal	**Response**	**Yes**	**No**
Advise CCGs to support prescribers in deprescribing bath and shower preparations in this category and substitute with "leave-on" emollients and, where appropriate, to ensure the availability of relevant services to facilitate this change	Agree	17	41
	Disagree	57	89
	Neither agree or disagree	4	6
	Unsure	7	6
	Percent disagree	**67%**	**63%**
Advise CCGs that prescribers in primary care should not initiate bath and shower preparations for any new patient.	Agree	4	27
	Disagree	74	113
	Neither agree or disagree	0	1
	Unsure	7	2
	Percent disagree	**87%**	**79%**

Blood glucose testing strips

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

		Disability	
Proposal	**Response**	**Yes**	**No**
Advise CCGs to support prescribers in deprescribing blood glucose testing strips that cost more than £10 for 50 strips and where appropriate, ensure the availability of relevant services to facilitate this change	Agree	39	45
	Disagree	62	41
	Neither agree or disagree	4	5
	Unsure	4	5
	Percent disagree	**57%**	**43%**
Advise CCGs that prescribers in primary care should not initiate blood glucose testing strips that cost more than £10 for 50 strips for any new patient.	Agree	27	35
	Disagree	74	51
	Neither agree or disagree	6	6
	Unsure	4	4
	Percent disagree	**67%**	**53%**

Dronedarone

Patients considering themselves to have a disability felt more strongly about the proposals, though this may be due to small numbers of respondents.

		Disability	
Proposal	**Response**	**Yes**	**No**
Advise CCGs that prescribers should not initiate dronedarone in primary care for any new patient	Agree	0	9
	Disagree	4	5
	Unsure	0	1
	Percent disagree	**100%**	**33%**
Advise CCGs that if, in exceptional circumstances, there is a clinical need for dronedarone to be prescribed, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.	Agree	4	10
	Disagree	0	4
	Unsure	0	1
	Percent disagree	**0%**	**27%**

Needles for pre-filled insulin pens

Patients considering themselves to have a disability disagreed more strongly with the proposal on advising not to initiate patients. They disagreed to the same extent as those not considering themselves to have a disability with the other proposal.

		Disability	
Proposal	**Response**	**Yes**	**No**
Advise CCGs to support prescribers in deprescribing insulin pen needles that cost more than £5 per 100 needles and, where appropriate ensure the availability of relevant services to facilitate this change.	Agree	35	42
	Disagree	51	54
	Neither agree nor disagree	6	5
	Unsure	8	4
	Percent disagree	**51%**	**51%**
Advise CCGs that prescribers in primary care should not initiate insulin pen needles that cost more than £5 per 100 needles for any new diabetes patient.	Agree	17	35
	Disagree	71	62
	Neither agree nor disagree	6	3
	Unsure	6	5
	Percent disagree	**71%**	**59%**

Rubefacients

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

		Disability	
Proposal	**Response**	**Yes**	**No**
Advise CCGs to support prescribers in deprescribing insulin pen needles that cost more than £5 per 100 needles and, where appropriate ensure the availability of relevant services to facilitate this change.	Agree	33	69
	Disagree	34	30
	Neither agree nor disagree	44	37
	Unsure	29	36
	Percent disagree	**24%**	**17%**
Advise CCGs that prescribers in primary care should not initiate insulin pen needles that cost more than £5 per 100 needles for any new diabetes patient.	Agree	25	64
	Disagree	46	40
	Neither agree nor disagree	40	32
	Unsure	30	35
	Percent disagree	**33%**	**23%**