Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Policy for Items which should not be routinely prescribed in Primary Care

Before completing this equality analysis, it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

NHS Birmingham CrossCity Clinical Commissioning Group
NHS Birmingham South Central Clinical Commissioning Group
NHS Solihull Clinical Commissioning Group

1. Background

EA Title	Policy for Items which should not be routinely prescribed in Primary Care		
EA Author	Michelle Dunne	**Team**	Quality/ Medicines Management
Date Started	15th February 2018	**Date Completed**	7th March 2018
EA Version	V0.2	**Reviewed by E&D**	

What are the intended outcomes of this work? Include outline of objectives and function aims

NHS England gateway publication 07448 developed guidance to support CCGs fulfil their duties around the appropriate use of resources. The objective of the guidance was to support CCGs in their decision making, to address unwarranted variation and to provide clear national advice to make local prescribing practices more effective.

The Birmingham and Solihull CCGs have considered the NHS England guidance and have produced a draft policy which details the items which will not be routinely prescribed in primary care, based on the documents produced by NHS England. A full equality analysis was undertaken by NHS England this included a 3-month consultation.

18 medications were identified for inclusion in policy of products which should no longer be routinely prescribed in primary care. These products all fell into one or more of the following categories:

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

The 18 medications are:

Drug	Purpose
Prolonged release doxazosin	Hypertension
Perindopril arginine	Hypertension
Dosulepin	Mental Health
Trimipramine	Mental Health
Glucosamine and chondroitin	Other
Herbal treatments	Other
Homoeopathy	Other
Liothyronine	Other
Lutein and antioxidants	Other
Omega 3 fatty acid compounds	Other
Once daily Tadalafil	Other
Travel vaccines	Other
Co-proxamol	Pain

Lidocaine plasters	Pain	
Oxycodone & naloxone combination product	Pain	
Parcetamol & tramadol combination product	Pain	
Rubifacients	Pain	
Immediate release fentanyl	Pain	

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

Staff – mainly primary care prescribers who prescribe items in the policy. 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 currently receive the prescription items detailed in the policy.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
Equality and Health Inequalities – Full Analysis – Items which should not be routinely prescribed in primary care		
NHS England Gateway Publication 07448		
https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/		

3. Impact and Evidence:

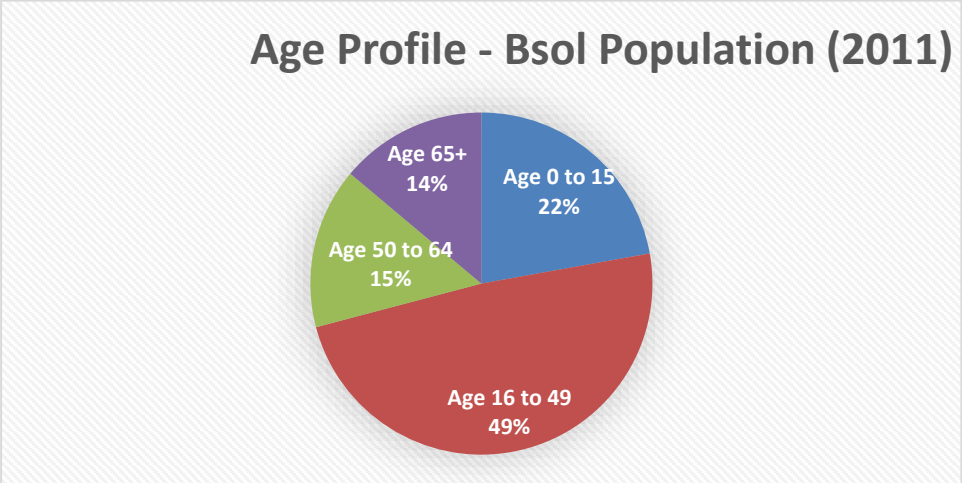
In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

The age profile for Birmingham and Solihull (Census 2011) demonstrates that nearly half of the population are aged between 16 and 49; nearly 30% are aged 50+.

Birmingham is characterised by its young population, which is especially true in the inner city areas. Just over 22% of the population are aged between 0 to 15 years in Birmingham, compared to 19% in Solihull. The Solihull population is relatively stable with the older population - 65+ representing just over 19% of the total population compared to 13.8% in Birmingham.

3. Impact and Evidence:



The experience of good health decreases with age; census findings for Birmingham and Solihull demonstrate this in the table below, where nearly 20% of those aged 65 and over experience bad or very bad health compared to 3.5% of those aged 16 to 49 and 11.8% of those aged 50 to 64.

Age	All categories: Age	Age 0 to 15	Age 16 to 49	Age 50 to 64	Age 65 and over
General Health					
All categories: General health	1279719	283863	623381	194666	177809
Very good or good health	1021352	272388	544744	127642	76578
Fair health	175838	8803	57066	43873	66096
Bad or very bad health	82529	2672	21571	23151	35135

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. (ref: http://content.digital.nhs.uk/catalogue/PUB16076/HSE2013-Ch5-pres-meds.pdf) this is demonstrated in the local data for 2016/17 which shows usage of the medications by age group:

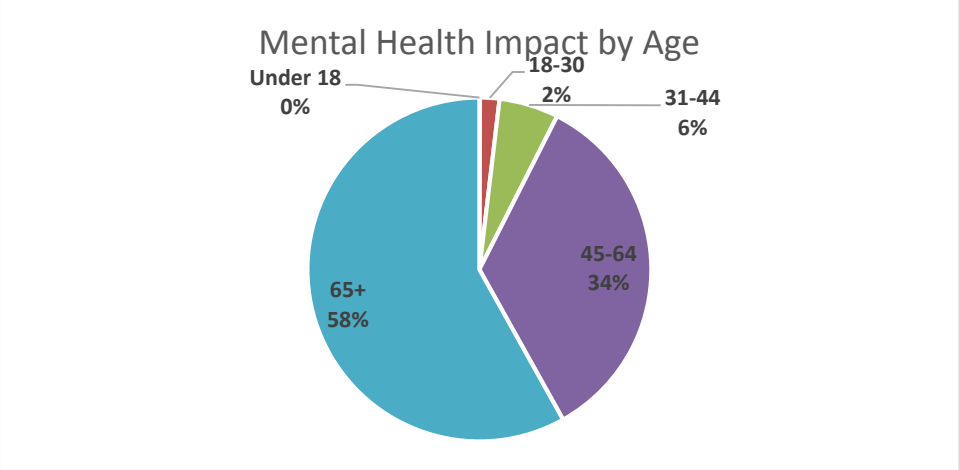
Purpose	**Drug**	**Under 18**	**18-30**	**31-44**	**45-64**	**65+**	**Totals**
Pain	Co-proxamol	0	1	2	35	126	**164**
	Immediate release fentanyl	0	0	7	13	11	**31**
	Lidocaine plasters	4	39	155	379	480	**1057**
	Oxycodone & naloxone	0	6	16	53	44	**119**
	Parcetamol & tramadol	2	67	190	450	479	**1188**
	Rubifacients	398	754	2012	4580	6505	**14249**

3. Impact and Evidence:

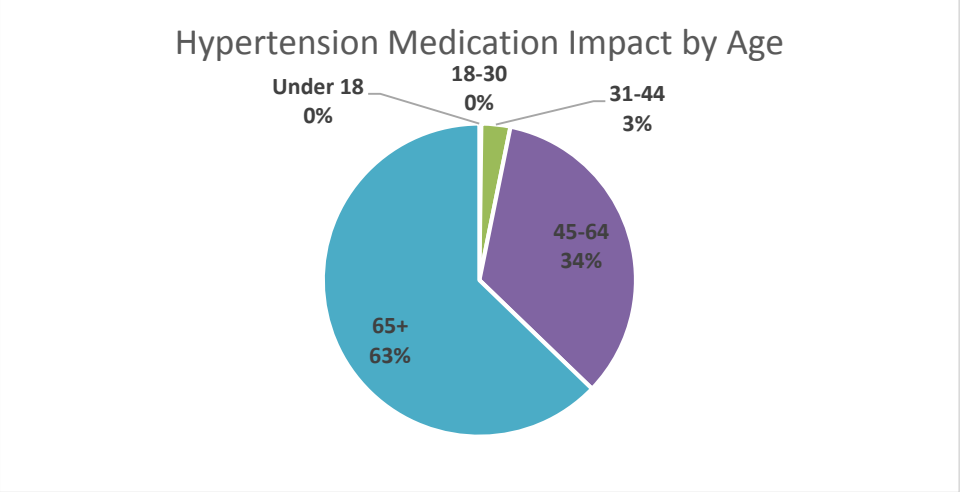
	Dosulepin	1	31	94	589	975	**1690**
Mental Health	Trimipramine	0	1	4	15	44	**64**
	Prolonged release doxazosin	0	3	53	628	1200	**1884**
Hypertension	Perindopril arginine	0	2	22	226	376	**626**
	Glucosamine & chondroitin	0	0	1	12	13	**26**
	Herbal treatments	51	32	68	75	58	**284**
	Homoeopathy	67	1	1	6	13	**88**
	Liothyronine	0	2	16	48	25	**91**
	Lutein and antioxidants	0	0	0	1	11	**12**
	Omega 3	0	10	51	363	276	**700**
	Once daily Tadalafil	0	16	91	546	383	**1036**
Other	Travel vaccines	236	269	248	295	160	**1208**

Local data analysis:

Mental Health Medication – the over 65 age group are the largest impacted group at 58%, with those aged 45 to 64 the second at 34%

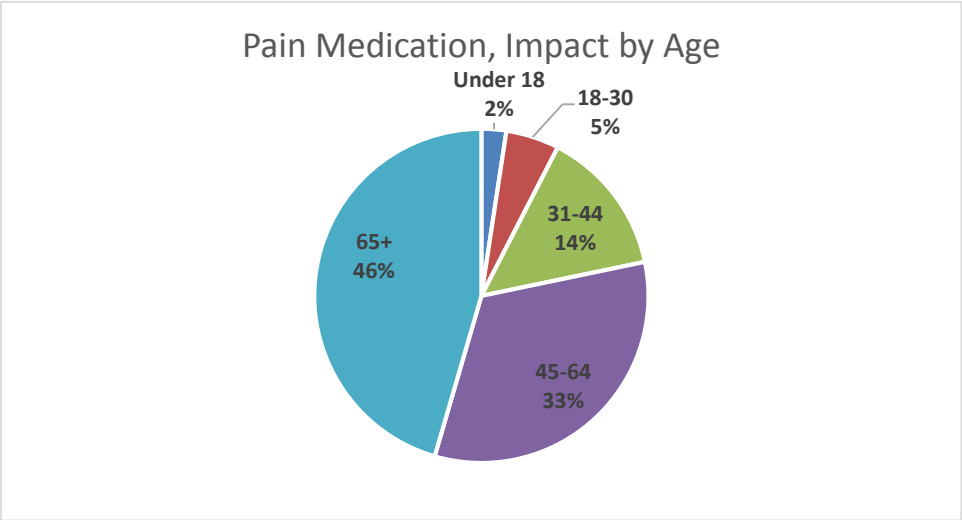


Hypertension Medication – again the largest impact is in the 65+ age group – 63%, and then the 45 to 64 age group at 34%

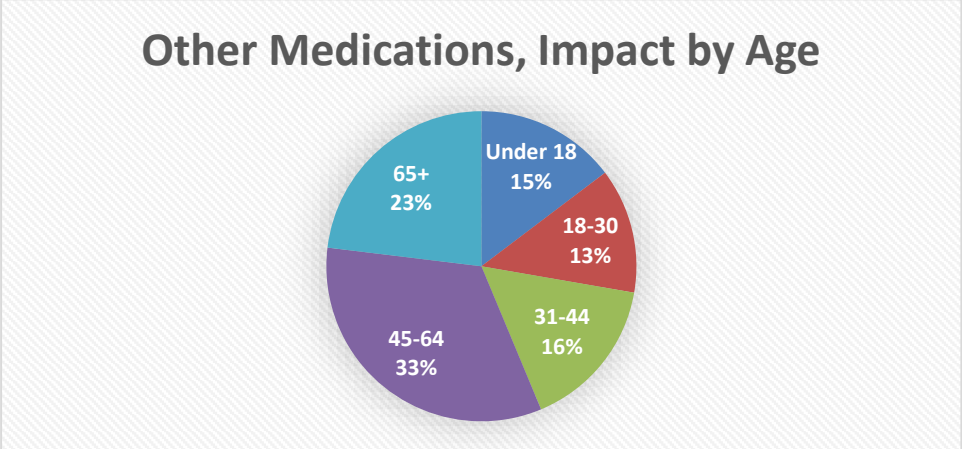


3. Impact and Evidence:

Pain Medication – similarly the largest impacted group is those aged 65+ at 46% followed by those aged 45-64 – 33%



Other Medication – the impact is wide-ranging affecting all age groups to some degree; with the age 45 to 64 group most affected – 33%.



The impact of the decision to not prescribe these medications will affect many age groups, with some significant impact experienced by the older aged population (in particular some depression, pain and hypertension medications).
It will particularly important that prompt reviews of treatment are undertaken for all patients affected – this is likely to benefit older patients through optimisation of their treatment. It could assist in potentially reducing harm caused by certain medicines of which older people are more likely to receive.
Effective communication of the changes will be important for all patients, but particularly on the more vulnerable patients including those in care settings and those who don't have the capacity to make their own decisions.

3. Impact and Evidence:

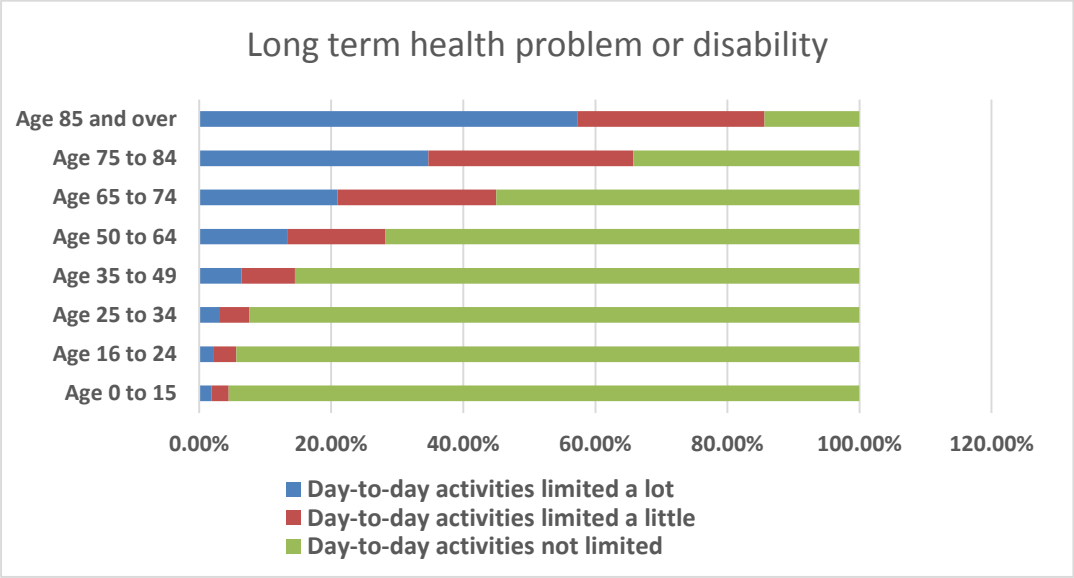
Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

There is no routinely collected data on prescribing and disability so we cannot definitively assess fully at either a national or local 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.

Local data – Age and impact of Long term health conditions/disability on ability to undertake day to day activities:

The following graph (compiled using 2011 census data details by age for the whole Bsol population whether they have a long term health problem or disability and if this affects their day to day activities.

The graph shows the increase in impact on day to day activities in older aged group, with over 80% of those aged 85 or over stating that their activities are either limited a lot or a little due to a long term health problem or disability.



As part of the National online consultation survey respondents were asked 'do you feel there are any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?'. 45% stated yes, 33% No and 22% Prefer not to say. Respondents were then asked 'Which groups do you think will be effected?' 63% highlighted disability. The following themes/statements emerged in relation to disability:

- 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)

3. Impact and Evidence:

- Adversely affects those who cannot communicate their reliance on NHS-provided treatments, due to disability/age/computer literacy.
- 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.
- Consider the implications for patients having to travel to hospital to collect their prescription (lidocaine plasters)
- Restricting primary care prescribing of lidocaine plasters will significantly disadvantage pain and palliative care patients.

The CCG policy and procedures for implementing the removal of the medications from primary care prescribing will need to ensure that the above factors are considered.

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

There is no routinely collected data on prescribing and gender reassignment (locally and nationally) so we cannot definitively assess, how many people will be affected. None of the items included in the proposed policy are used for the purposes of gender reassignment.
During the national consultation, responses were monitored to ascertain if there were any likely unintended consequences on this protected characteristic. There were no results from the consultation that indicated this.

Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:

There is no routinely collected data on prescribing and marriage/civil partnership so we cannot definitively assess (at a local or 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 national consultation, responses were monitored to ascertain if there were any likely unintended consequences on this protected characteristic. There were no results from the consultation that indicated this.

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

3. Impact and Evidence:

There is no routinely collected data on prescribing and pregnancy/maternity so we cannot definitively assess (at a local or national level), how many people who are pregnant/on maternity leave will be affected.

None of the items proposed in the guidance are used for conditions that are closely related to pregnancy or maternity. Primary Care 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 this protected characteristic. There were no results from the consultation that indicated this.

Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:

There is no routinely collected data on prescribing and race so we cannot definitively assess, at a national or local level, how many people will be affected.

Local statistics (Bsol) on Race (Census 2011):

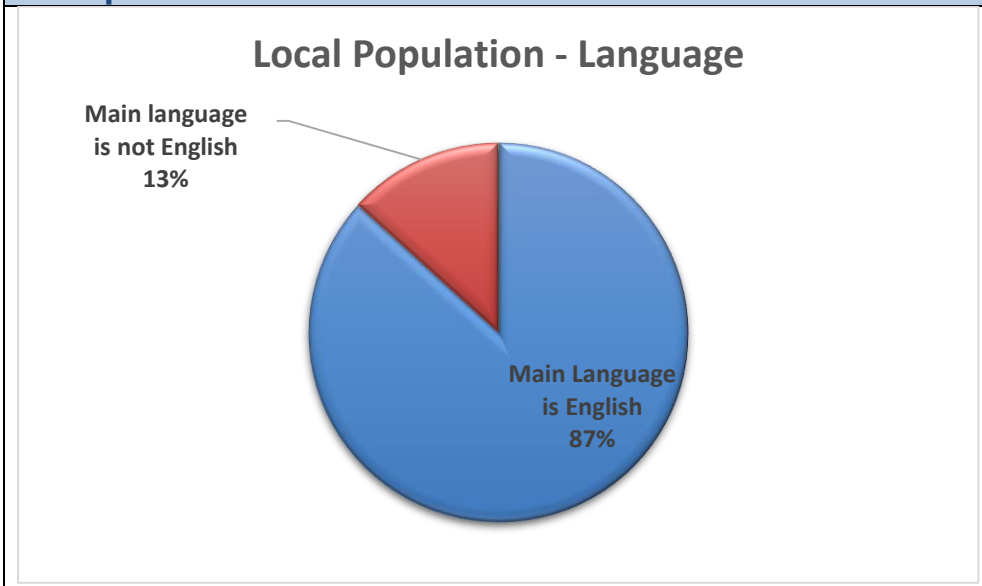
All usual residents	**1,279,719**
White/White British	62.97%
Mixed/Multiple ethnic group	4.06%
Asian/Asian British	23.38%
Black/African/Caribbean/Black British	7.78%
Other ethnic group	1.79%

The Local Chinese community accounts for 1.06% of the population of Birmingham and Solihull (13,618 people at the time of the census).

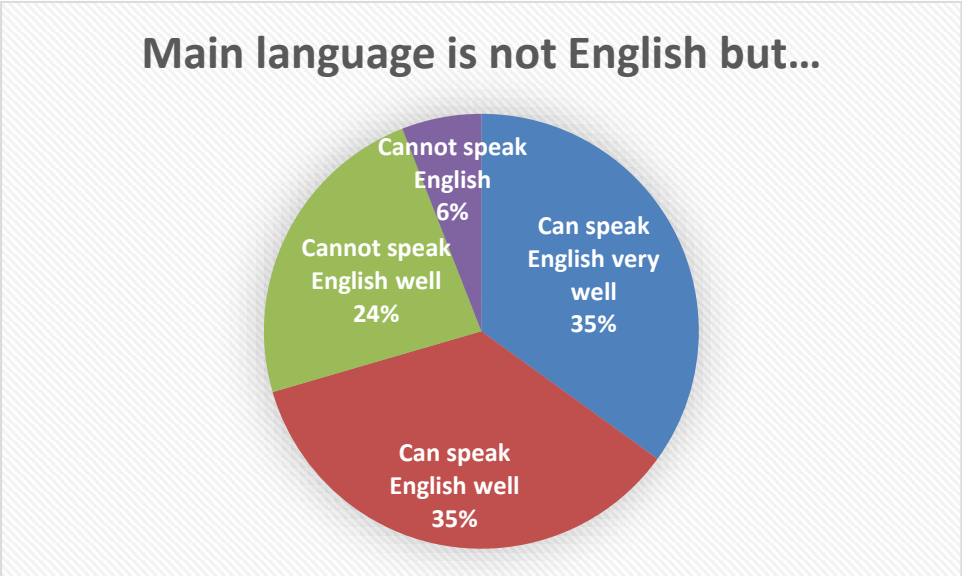
Local statistics on Language (Census 2011):

In Birmingham and Solihull, 13% of the population indicate that English is not their main language:

3. Impact and Evidence:



Where English is not the main language, the Census asked about respondent's ability to speak English; this found that 30% can either not speak English well or cannot speak English at all.



During the national 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. As part of the online consultation survey respondents were asked 'do you feel there are any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?'. 45% stated yes, 33% No and 22% Prefer not to say. Respondents were then asked 'Which groups do you think will be effected?' 12% highlighted race. The following themes emerged in relation to race:

- The need for further communication/assistance for BME communities and those with poor English.

3. Impact and Evidence:

- 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

The above findings will need to be considered in the implementation of the policy and procedures at a local level, taking into account the local statistics and data.

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

There is no routinely collected data on prescribing and religious beliefs so we cannot definitively assess (at a local or 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 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.

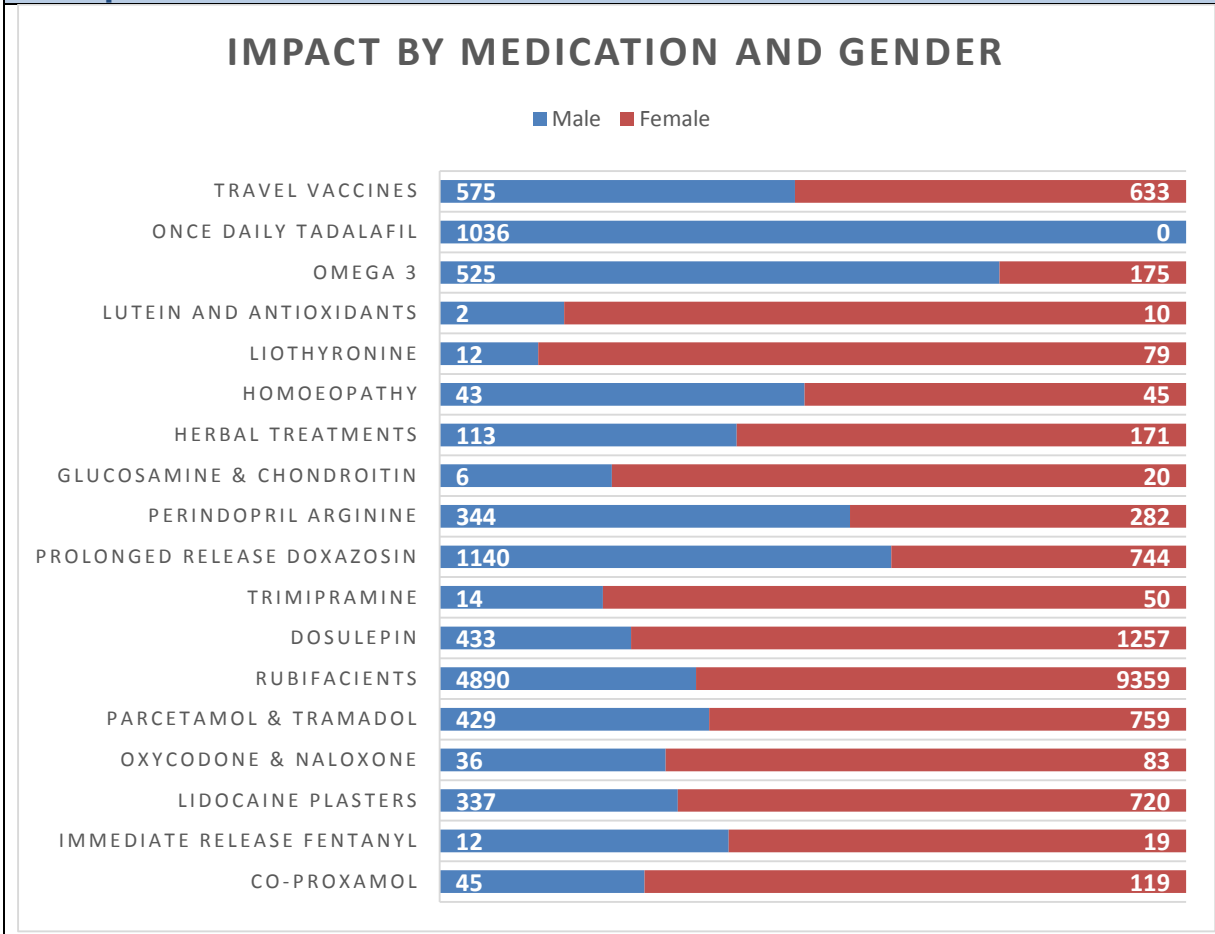
Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

Nationally, 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).

In Birmingham and Solihull, 51% of the population are female, 49% male.

Locally data on the medication usage by gender have been reviewed (2016/17 data) and is presented below:

3. Impact and Evidence:

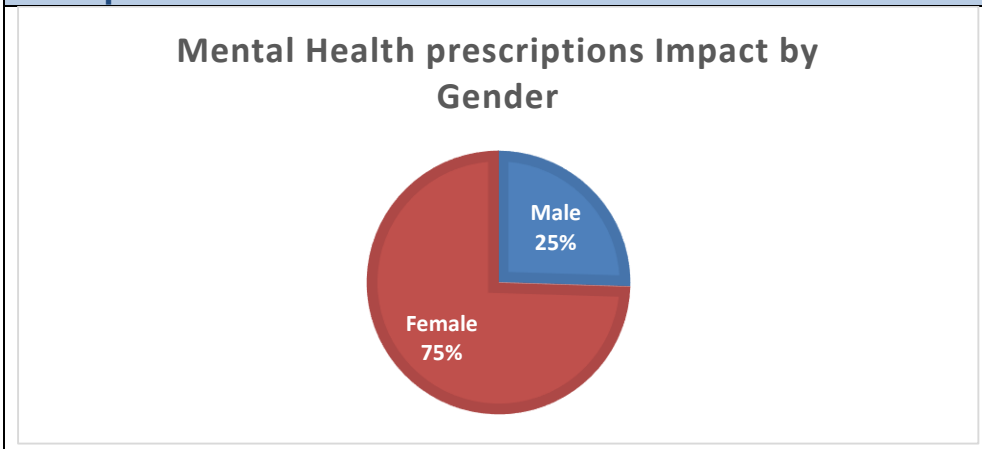


The table above details prescribing data for 2016/17, which indicates on average more females are prescribed these medicines than males (59.24% - females and 40.75% - males) this indicates that reviews and potential deprescribing may be most commonly required in women for the majority of medications, particularly the pain and depression medications where over 67% of those prescribed medications in 2016/17 were women.

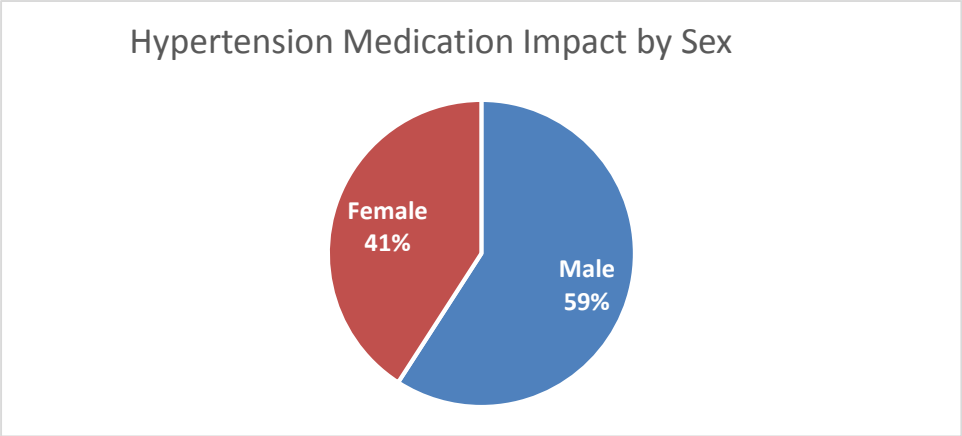
Local Data by Medication Purpose and Gender:

Mental Health Prescriptions – the graph below shows that 75% of users are women and so the impact on deprescribing of this type of medication will the greatest impact will be with this group.

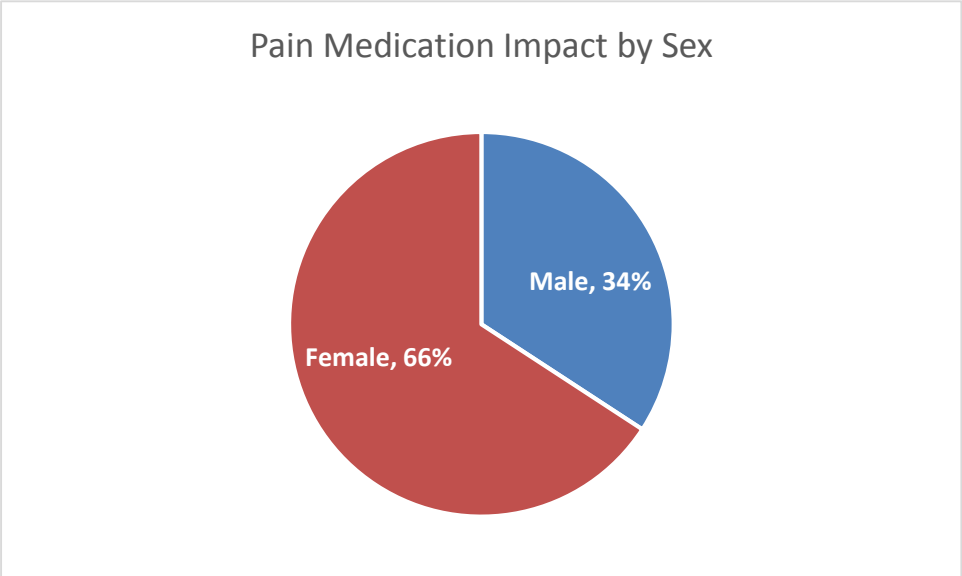
3. Impact and Evidence:



Hypertension Prescriptions – more Men than women are prescribed these medications and so the impact will be greater for them.

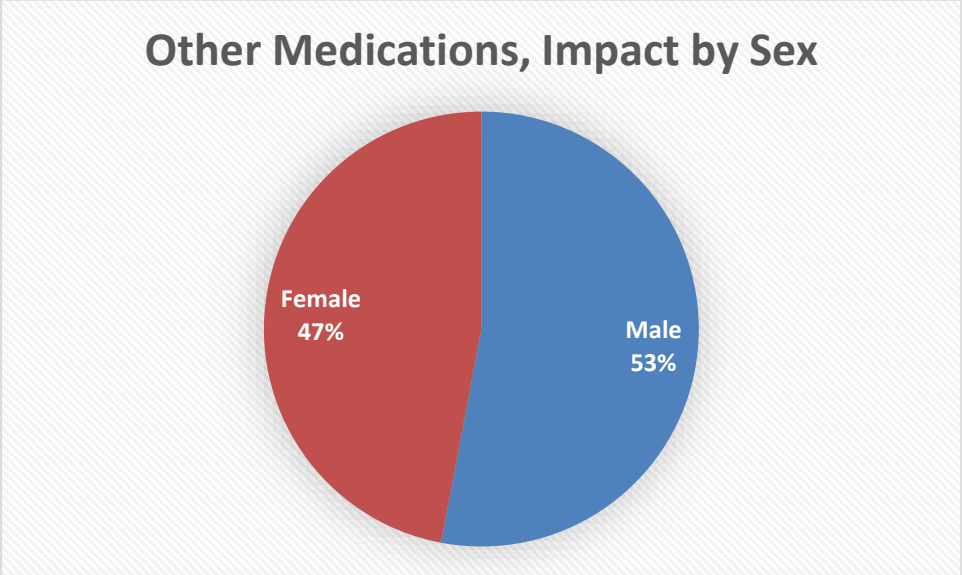


Pain Medication – the deprescribing of this medication will affect more women than men – with 66% of prescriptions being for women.



3. Impact and Evidence:

Other Medication – the impact of deprescribing the medications classed for 'other' purposes has a similar impact across both sexes. Note that the Once Daily Tadifil prescription is not included in the chart below as this is only prescribed to men.



Liothyronine Medication:
As part of the National online consultation survey respondents were asked 'do you feel there are any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?'. 45% stated yes, 33% No and 22% Prefer not to say. Respondents were then asked 'Which groups do you think will be effected?' 31% highlighted sex. The following statement emerged in relation to sex:

- That the removal of liothyronine will adversely affect many people, mainly women who are more prone to hypothyroidism.

Analysis of local data (for liothyronine) revealed that 91 users identified for the Bsol CCG – 13% males and 87% females, which supports the findings of the national consultation i.e. more likely to affect females.

As a result of the responses to the national consultation around liothyronine it was decided that the recommendation would be changed to:

- Individuals currently prescribed Liothyronine would be reviewed by an NHS endocrinologist with consideration given to switching to levothyroxine where clinically appropriate.
- Where levothyroxine has failed and in line with the British Thyroid Association guidance, endocrinologists may prescribe liothyronine for individual patients after a carefully audited trial of at least 3 months' duration of liothyronine.

3. Impact and Evidence:

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

There is no routinely collected data on prescribing and sexual orientation so we cannot definitively assess (at a local or national level) how many people will be affected. There is no established link between prescribing of items proposed in the guidance and sexual orientation.

During 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.

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

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

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

Alcohol and/or drug misuser
None of the medicines in the review are specifically used in the treatment of addiction (alcohol and/or drug misusers). There is no data available on the prevalence of alcohol or drug users who are currently prescribed the medications in the review. There was no indication from the national consultation that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

Asylum seekers and/or refugees/ Carers/ Homeless
There is no data available on the prevalence with the above groups who are currently prescribed the medications in the review. There was no indication in the national consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	See below
Is there any impact for groups or communities living in particular geographical areas?	No	
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	

How will you ensure the proposals reduce health inequalities?

Currently patients could be receiving medication that are unsafe, ineffective or where there is a more cost effective alternative available. By implementing the national policy that includes review of patients taking these medications we will ensure that their treatment is optimised. This enables patients to have access to the most effective medications to achieve the best outcomes. It 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 through implementation of this policy.

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	All affected patients will be informed about medication changes and will (where necessary) have a review of their medication.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	GP practices are required to have in place policies regarding confidentiality and consent.
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	All affected patients will benefit through access to the most effective medications.
	How will this affect a person's right to freedom of thought, conscience and religion?	Not applicable
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	All providers of NHS health services are required to uphold the NHS constitution and uphold patient dignity.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	All affected patients will be informed about medication changes and will (where necessary) have a review of their medication.

Right to **Life**	Will or could it affect someone's right to life? How?	Currently patients could be receiving medication that are unsafe, ineffective or where there is a more cost effective alternative available. By implementing the national policy that includes review of patients taking these medications we will ensure that their treatment is optimised.
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No impact

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	This policy is not subject to procurement
Create fair employment and good work for all	
Create and develop health and sustainable places and communities	
Strengthen the role and impact of ill-health prevention	

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	**Protected Characteristic/ Group/ Community**	**Date**
Social media activity	All	July - October 2017
Newsletters	All	July - October 2017
Patient forums	All	July - October 2017
Focus Group with Solihull Thyroid group	Thyroid	13th October 2017

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

The national consultation was supported by the CCGs, via their own communications and engagement channels. This included information on websites, social media activity (including paid for Facebook promotion), internal and external newsletters, existing patent forums and a briefing to key stakeholders. The CCGs' communications and engagement team also created

standard content to support the consultation, which was used by NHS England and other CCGs in the Midlands and East.

Example content below:

Newsletters and web:

National consultation on medicines which should not be routinely prescribed

Last year, 1.1 billion prescription items were dispensed at a cost of £9.2 billion. This growing cost, coupled with finite resources, means it is important that the NHS achieves the greatest value from the money that it spends. We know that across England there is significant variation in what is being prescribed and to who. Often patients are receiving medicines which have been proven to be ineffective or in some cases dangerous, and/or for which there are other more effective, safer and/or cheaper alternatives. NHS England has partnered with NHS Clinical Commissioners to support Clinical Commissioning Groups (CCGs) in ensuring that they can use their prescribing resources effectively and deliver best patient outcomes from the medicines that their local population uses.

There is currently a consultation about 18 medicines, which cost the NHS of £141m a year (not including dispensing costs), that should not be routinely prescribed in primary care. These can be categorised into one of the following groups:

• The items are 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.
• Items which are clinically effective but, due to the nature of the product, are deemed a low priority for NHS funding.

In addition, your views are needed on some over-the-counter medicines. This includes over 3,200 products which the NHS in England spends approximately £645m a year on purchasing. These include products that:

• Can be purchased over the counter, and sometimes at a lower cost than would be incurred by the NHS;
• Treat a condition that is considered to be self-limiting and so does not need treatment as it will heal/be cured of its own accord; and/or
• Treat a condition which lends itself to self-care, i.e. that the person suffering does not normally need to seek medical care and/or treatment for the condition.

To read the FAQs about this consultation click here. To read the consultation document and complete the survey click here. The consultation closes on 21 October 2017.

Social media – Twitter:

Take part in @NHSCCPress & @NHSEngland consultation about 18 medicines, which cost the NHS £141m a year. Find out more http://bit.ly/2uQcp0E

Give your views on over the counter #medicines that cost the #NHS £645m a year. Find out more http://bit.ly/2uQcp0E

Have your say on a national #NHS #consultation about 18 #medicines by 21 October. Find out more: http://bit.ly/2uQcp0E

Give your views in the national #NHS #consultation about #medicines that shouldn't routinely be prescribed: http://bit.ly/2uQcp0E

Social media – Facebook:

NHS England and NHS Clinical Commissioners are currently running a national consultation about 18 medicines which should not be routinely prescribed.
These medicines cost the NHS of £141m a year (not including dispensing costs) and can be categorised into one of the following groups:

• The items are 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.
• Items which are clinically effective but, due to the nature of the product, are deemed a low priority for NHS funding.

In addition, your views are needed on some over-the-counter medicines. This includes over 3,200 products which the NHS in England spends approximately £645m a year on purchasing.

The consultation runs up until 21 October, and they'd like you to have your say.

You can find all of the information on the NHS England website here: http://bit.ly/2uQcp0E

Nationally the results of the consultation were published
https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-consultation-report-of-findings/

Local feedback from Thyroid focus group was also sought.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

NHS England and NHS Clinical Commissioners established a clinical working group, chaired by representatives of these two organisations, with membership including GPs and pharmacists, CCGs, Royal College of General Practitioners, National Institute for Health and Care Excellence, Department of Health, the Royal Pharmaceutical Society and others. This clinical working group was tasked with identifying which products should no longer be routinely prescribed in primary care.

In reaching its recommendations for the 18 products listed in the Bsol CCG policy, the group considered recommendations from NICE, where relevant and available. Where it was not available the group considered evidence from a range of sources, for example; the Medicines and Healthcare Products Regulatory Agency, the British National Formulary, the Specialist Pharmacist Service and PrescQIPP Community Interest Company evidence reviews.

The group reviewed each product against a set of criteria including:

- Legal status
- Efficacy
- Safety

- Alternative treatments and exceptionality for individuals
- Equalities and Health Inequalities
- Financial implications
- Unintended consequences

The group's recommendations on the 18 items were publicly consulted on for a period of 3 months. A detailed report on the consultation was published https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-consultation-report-of-findings/
Alongside guidance for CCGs https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-guidance-for-ccgs/
The final recommendations set out in the guidance for CCGs reflects the outcome of the consultation. An equality impact of these recommendations was also undertaken https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-equality-and-health-inequalities-full-analysis/

The national equality analysis stated that the following action should be taken by CCGs – "CCGs will also be required to assess the impact of their population with regard to the particular demographics of the population they serve".

In terms of the **local population the following impacts** have been identified:

Age
Mental Health Medication – the over 65 age group are the largest impacted group at 58%, with those aged 45 to 64 the second at 34%.

Hypertension Medication – again the largest impact is in the 65+ age group – 63%, and then the 45 to 64 age group at 34%

Pain Medication – similarly the largest impacted group is those aged 65+ at 46% followed by those aged 45-64 – 33%

The impact of the decision to not prescribe these medications will affect many age groups, with some significant impact experienced by the older aged population (in particular some depression, pain and hypertension medications).
It will particularly important that prompt reviews of treatment are undertaken for all patients affected – this is likely to benefit older patients through optimisation of their treatment. It could assist in potentially reducing harm caused by certain medicines of which older people are more likely to receive.
Effective communication of the changes will be important for all patients, but particularly on the more vulnerable patients including those in care settings and those who don't have the capacity to make their own decisions.

Disability
Findings from national consultation:
- 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.
- 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.
- Consider the implications for patients having to travel to hospital to collect their prescription (lidocaine plasters)
- Restricting primary care prescribing of lidocaine plasters will significantly disadvantage pain and palliative care patients.

Race
National consultation feedback:

- The need for further communication/assistance for BME communities and those with poor English.
- 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

Sex
On average more females are prescribed these medicines than males (59.24% - females and 40.75% - males) 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 67% of those prescribed medications in 2016/17 were women.

Mental Health Prescriptions –75% of users are women and so the impact on deprescribing of this type of medication will the greatest impact will be with this group.

Hypertension Prescriptions – more Men than women are prescribed these medications and so the impact will be greater for them.

Pain Medication – the deprescribing of this medication will affect more women than men – with 66% of prescriptions being for women.

Analysis of local data (for **liothyronine**) revealed that 91 users identified for the Bsol CCG – 13% males and 87% females, which supports the findings of the national consultation i.e. more likely to affect females.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

Recommendations – in terms of policy implementation:

- GP practices are reminded of the requirements of the Accessible Information Standard which requires that the information and communication needs of patients, service users, carers and parents with a disability, impairment or sensory loss are identified, recorded, flagged and met.
- All patients are contacted regarding changes in a timely manner and in a format which meets the patient's needs (accessible information standard).
- It will be particularly important that prompt reviews of treatment are undertaken for all patients affected – this is likely to benefit older patients through optimisation of their treatment. It could assist in potentially reducing harm caused by certain medicines of which older people are more likely to receive.
- Effective communication of the changes will be important for all patients, but particularly on the more vulnerable patients including those in care settings and those who don't have capacity to make their own decisions.
- Ensure that where patients for whom English is not their main language that an interpreter is available to assist at the consultation with their GP.
- The methods for communicating this policy to the wider population as well as affected patients is accessible and easily understood.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

N/A

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

N/A

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages.

Birmingham and Solihull CCG webpages

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager **and** signed-off by a delegated committee

	Name	**Date**
Quality Assured By:	MK Dunne	7th March 2018
Which Committee will be considering the findings and signing off the EA?	Clinical Policy Sub-Group	8th March 2018
Minute number (to be inserted following presentation to committee)	Item 8	