Community Pharmacy Scotland

NHS England consultation - Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs

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Who are Community Pharmacy Scotland (CPS) & what do they do?

Who we are

We are the organisation which represents community pharmacy contractor owners in almost every aspect of their working lives, and are the voice of these vital healthcare professionals as they deliver pharmaceutical care to the people of Scotland.

We are empowered to represent the owners of Scotland's 1256 community pharmacies and negotiate on their behalf with the Scottish Government. This covers all matters of terms of service and contractors' NHS service activity including remuneration and reimbursement for the provision of NHS pharmaceutical services.

What we do

We work with the Scottish Government on the development of new pharmaceutical care services and ensure that the framework exists to allow the owners of Scotland's community pharmacies to deliver these services.

The Scottish community pharmacy contract puts the care of the individual right at its centre and with its focus on pharmaceutical care and improving clinical outcomes, community pharmacy contractors and their employee pharmacists are playing an increasingly important role in maximising therapeutic outcomes and improving medicine safety. Community pharmacy is at the heart of every community and plays an important part in the drive to ensure that the health professions provide the services and care the people of Scotland require and deserve.

Community Pharmacy Scotland

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Introduction

CPS has already responded to the two NHSE consultations which preceded this latest set of guidelines for CCGs. Our rationale for responding to an England-only consultation remains that our NHS Scotland colleagues will look south of the border to existing guidance when deciding how best to make efficiencies in a financially challenging climate. Whilst this is not necessarily a bad thing, some of the guidance that has emerged so far would have a negative impact on contractors and the communities they serve.

The “Low priority prescribing” project group will continue to work indefinitely to produce guidance which reflects best value for NHS money. Their approach is to identify and assess items which are deemed as:

- Of low clinical effectiveness or have significant safety concerns
- Are clinically effective but there are more cost-effective products available (Includes products which have been subject to “excessive price inflation”)
- Are clinically effective, but due to the nature of the product, are deemed a low priority for NHS funding.

The full consultation document can be accessed here. Our draft response is included below for simplicity.

1. Do you feel there is 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 black and minority ethnic (BME) communities?

Yes – where recommendations include deprescribing items, there must be guidance provided as to a suitable alternative treatment available on the NHS for those who have been experiencing a benefit from a given treatment. If the only alternative is for them to either continue to use the product but pay for it themselves or to suffer a decline in their condition, this is unacceptable.

2. Thinking about the process for future update and review of the guidance:
How do you feel about the proposed process for identification of items for possible addition to the guidance or indeed possible removal, from the guidance?

We are supportive of the rationale behind identifying items with a lack of robust evidence for clinical effectiveness or significant safety concerns. However, we are uncomfortable with the other two classifications which are used, particularly as there does not appear to be consultation with potentially affected patients unless local CCGs decide to carry one out and include their views in the response to this consultation. This leads to questions over who decides what is "low priority" for NHS funding – surely this will be different for each individual as their ability to (for example) pay for a recommended or deprescribed therapy will vary, as will their experience of their disease.

3. Do you agree with the proposed recommendations for Rubefacients (excluding topical NSAIDs)?

No. For those that cannot tolerate topical NSAIDs and for whom capsaicin creams would be inappropriate, prescribers should be able to initiate rubefacients as long as their use is reviewed before issuing further prescriptions. This would only be as a stop-gap in cases where services to improve osteoarthritic pain were not immediately accessible.

4. Do you agree with the proposed recommendations for Aliskiren?

No. If Aliskiren cannot be initiated in primary care (which we agree with), it should not be deprescribed in primary care without discussion with a secondary care specialist, much like the proposals for Amiodarone.

5. Do you agree with the proposed recommendations for Amiodarone?

Yes.

6. Do you agree with the proposed recommendations for bath and shower emollient preparations?

Yes – however, prescribers must ensure that sufficient quantities of “leave-on” emollients are provided to patients so that they can be used daily as soap replacements and for moisturising as required.

7. Do you agree with the proposed recommendations for blood glucose testing strips?

No – A person-centred approach must always be taken and if the most appropriate device to help a patient control their type-2 diabetes is one which has strips costing over £10/50 strips, a prescriber should be able to initiate it.
We are not convinced that the proposed change will deliver the intended savings and see little evidence of a full cost-benefit analysis presented. We are concerned that putting this measure into place will drive prescribing or manufacturer behaviour down unintended routes e.g. manufacturers beginning to charge patients or the NHS for meters where they currently do not, or prescribers being forced to select meters for their patients which are not best suited to their needs.

8. Do you agree with the proposed recommendations for Dronedarone?

Yes.

9. Do you agree with the proposed recommendations for Minocycline?

Yes.

10. Do you agree with the proposed recommendations for needles for pre-filled and reusable insulin pens?

No. We would suggest that the arbitrary selection of "under £5" as the price which is deemed acceptable to the NHS carries a risk in that the majority of the products in the market are currently priced above this. We can see that this guidance may cause some prices to fall below £5, but if this does not happen, a significant and immediate burden will be placed upon the manufacturers who do have products in the recommended range. This may cause shortages as demand outstrips supply, as we have seen with several medicines in Scotland in recent years.
This cutoff also allows little in the way of flexibility to account for inflation or indeed other unforeseen increases in the market. We would suggest that a higher cutoff such as £10 is chosen instead, which would still deliver significant savings to the NHS.

11. Do you agree with the proposed recommendations for silk garments?

No. Whilst we appreciate that the CLOTHES Study was robust, the power of the study was low and although the average improvement was little to none, there were some children and parents interviewed who reported that the eczema symptoms got better. We agree that these should only be initiated in secondary care, but would again comment that any deprescribing must be done in partnership with a dermatologist as well.