Community Pharmacy Scotland

CPS response to NHS England Items Which Should Not Be Routinely Prescribed: A Consultation on 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.

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Equality and Health Inequalities

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

No

Equality and Health Inequalities - continued

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?

Yes

Please provide further information on why you think this might be the case:

This will undoubtedly impact on health inequalities experienced by people on low incomes, who rely on the "free at the point of access" element of the NHS to ensure they receive safe and effective care.

Those with learning difficulties or learning disabilities require additional support from community pharmacists and their teams to ensure optimum pharmaceutical care with the supply of medicine. This applies particularly to the medicines in Section 5. The removal of supply from pharmacies will certainly lead to specific groups choosing to obtain their medication from the lowest-priced source. Whether this is a supermarket, a bargain shop or online, these individuals will miss out on crucial health interventions, optimisation of medicines use and safety advice from pharmacy professionals.

How will the guidance be updated and reviewed?

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?

Disagree

If needed, please provide further information:

Community Pharmacy Scotland (CPS) are concerned that once medications are confirmed as "not routinely prescribed" the occasions where they should be used will be overlooked (for example the Immediate Release Fentanyl for specific breakthrough cancer pain). The "non-routine" prescribing indications must be highlighted, the treatment guidelines followed and prescribing reviews completed at regular intervals to confirm compliance.

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Proposals for CCG Commissioning Guidance

Do you want to provide views on the proposals for CCG commissioning guidance?

Yes

Co-proxamol

Advise CCGs that prescribers in primary care should not initiate co-proxamol for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing co-proxamol in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Advise CCGs that if, in exceptional circumstances, there is a clinical need for co-proxamol to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

Agree

Dosulepin

Advise CCGs that prescribers in primary care should not initiate Dosulepin for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing Dosulepin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

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Advise CCGs that if, in exceptional circumstances, there is a clinical need for Dosulepin to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

Agree

Glucosamine and Chondroitin

Advise CCGs that prescribers in primary care should not initiate Glucosamine and Chondroitin for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing Glucosamine and Chondroitin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Herbal Treatments

Advise CCGs that prescribers in primary care should not initiate herbal items for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing herbal items in all patients and where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Homeopathy

Advise CCGs that prescribers in primary care should not initiate homeopathic items for any new patient.

Agree

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Advise CCGs to support prescribers in deprescribing homeopathic items in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Immediate Release Fentanyl

Advise CCGs that prescribers in primary care should not initiate Immediate Release Fentanyl for any new patient.

Unsure

Advise CCGs to support prescribers in deprescribing Immediate Release Fentanyl in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Unsure

Advise CCGs that if, in exceptional circumstances, there is a clinical need for Immediate Release Fentanyl to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

Unsure

If needed, please provide further information:

CPS are concerned that once medications are confirmed as "not routinely prescribed" the occasions where they should be used will be overlooked. Immediate Release Fentanyl is a key example of this. It is detailed as being licensed for breakthrough cancer pain for patients on opioid therapy equivalent to at least 60mg of oral morphine. The "nonroutine" prescribing indications must be highlighted and treatment guidelines followed to ensure these patients receive this medication.

We would suggest that in cases where current prescribing volumes appear excessive for a given indication, the appropriate and proportionate response to this would be investigation down to prescriber level, with corrective education/training being carried out to address the discrepancy. To label a medication as "not to be used" runs the risk of appropriate use being adversely affected.

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Lidocaine Plasters

Advise CCGs that prescribers in primary care should not initiate Lidocaine plasters for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing lidocaine plasters in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Omega-3 Fatty Acid Compounds

Advise CCGs that prescribers in primary care should not initiate Omega-3 Fatty Acids for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing Omega-3 Fatty acids in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Once Daily Tadalafil

Advise CCGs that prescribers in primary care should not initiate once daily Tadalafil for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing once daily Tadalafil in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

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Oxycodone and Naloxone Combination Product

Advise CCGs that prescribers in primary care should not initiate Oxycodone and Naloxone combination product for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing Oxycodone and Naloxone combination product in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Advise CCGs that if, in exceptional circumstances, there is a clinical need for Oxycodone and Naloxone combination product to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

Agree

Paracetamol and Tramadol Combination Product

Advise CCGs that prescribers in primary care should not initiate Paracetamol and Tramadol combination product for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing Paracetamol and Tramadol combination product in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Perindopril Arginine

Advise CCGs that prescribers in primary care should not initiate Perindopril Arginine for any new patient.

Agree

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Advise CCGs to support prescribers in deprescribing Perindopril Arginine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Prolonged-release Doxazosin

Advise CCGs that prescribers in primary care should not initiate Prolonged-release Doxazosin for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing Prolonged-release Doxazosin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Advise CCGs that if, in exceptional circumstances, there is a clinical need for Prolonged-release Doxazosin to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

Agree

Rubefacients (excluding topical NSAIDs)

Advise CCGs that prescribers in primary care should not initiate Rubefacients (excluding topical NSAIDs) for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing Rubefacients (excluding topical NSAIDs) in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

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Travel Vaccines

Advise CCGs that prescribers in primary care should not initiate the stated travel vaccines for any new patient

Disagree

CPS advise that these should be provided on the NHS. Travel to areas where these diseases are endemic is not unusual for people on both business and pleasure travel. The resulting costs of treating these illnesses on return to the UK, coupled with the risk of infection of others for contagious conditions far outweighs any costs associated with supply and administration of vaccines.

Trimipramine

Advise CCGs that prescribers in primary care should not initiate Trimipramine for any new patient.

Agree

Advise CCGs to support prescribers in deprescribing Trimipramine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

Agree

Advise CCGs that if, in exceptional circumstances, there is a clinical need for Trimipramine to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

Agree

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Items that are prescribed in primary care and are available over the counter

Please provide your views and/or any relevant evidence that we should consider when developing proposals to potentially restrict items that are available over the counter.

Please provide your views and/or any relevant evidence that we should consider when developing proposals to potentially restrict items that are available over the counter. :

CPS disagree completely with the proposal to limit prescribing of OTC items for minor ailments.

Such a restriction would undoubtedly impact on health inequalities experienced by people on low incomes, who rely on the "free at the point of access" element of the NHS to ensure they receive safe and effective care.

GPs may find themselves in a position of prescribing more potent, and indeed expensive treatments to provide care to these patients.

Those with learning difficulties or learning disabilities require additional support from community pharmacists and their teams to ensure optimum pharmaceutical care with the supply of medicine.

CPS advises a review of the current Minor Ailment Services in England, and advocate the adoption of a National Minor Ailment Service through Community Pharmacy.

This service:

- Provides wide access for patients across the community pharmacy network, in both location and opening hours.
- Patients receive a consultation, advice, along with prescribed medication if required, or referral to another healthcare provider.
- Frees up time for GPs.
- Is cost effective – community pharmacy average consultation cost of £32, vs £80 for GP and £140 for hospital.

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Do you agree with our proposed criteria to assess items for potential restriction?

Disagree

If needed, please provide further information.:

CPS advise that the Unintended Consequences (Appendix 2) are significant and are likely to impact negatively on person-centred pharmaceutical care. As per our answer to Section 5 (above and below) we disagree entirely with this proposal.

Even if CPS were in favour of the principles behind this proposal, we would suggest that without expert medical and pharmaceutical interpretation of data collected about each medicine, these criteria are not sufficient. To highlight our concern, Paracetamol can be used as an example. It is safe, effective and its indications are clear. It may be purchased OTC from a number of outlets for as little as 17p. However, if just one person in a household required the recommended dose of two tablets four times daily for osteoarthritis, then even where a pharmacy can supply up to 100 tablets in a single transaction if appropriate, this would last for a maximum of twelve days, necessitating several return trips to the place of purchase for the patient which may incur unnecessary cost, time spent and suffering endured depending on the ailment. In addition, there would be in many cases no pharmaceutical care provided where place of purchase is not a pharmacy, and absolutely no overarching record of self-directed healthcare interventions. For example, where a GP or Minor Ailments Service route of supply would pick up that a patient was experiencing alternating bowel habits (A red flag symptom for cancer amongst other diseases), this would not be the case for those purchasing remedies over the counter in a shop.

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- Frees up time for GPs.
- Is cost effective.

Are there individual products, which are either clinically ineffective or available over the counter which you believe should be prioritised for early review?
Please give detailed reasons for your response. :

No.

CPS completely oppose the removal of effective medicines. There is no evidence base for this proposal.