Community Pharmacy Scotland

Community Pharmacy Scotland response to: NHS England's consultation - 'Conditions for which over the counter items should not be routinely prescribed in primary care'

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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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Background

Following on from last year's consultation on Items which should not be routinely prescribed in primary care, NHS England are now consulting on their proposal to create national guidance for CCGs which would severely limit the treatment of 33 minor conditions on the NHS as a cost efficiency exercise. The consultation can be found here, and the CPS response in included below.

Q1. Do you feel there are any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?

Yes. Those who would have had their health needs met by the NHS on grounds of age will now be expected to pay for their own treatment for a number of conditions. Health deteriorates with age, and as such this group will have proportionately more minor ailments per year than other groups and thus will incur greater costs. Over 2 million people of pensionable age in the UK live in poverty (Source: Age UK), and we reject the notion that a prescriber would have all of the necessary information at hand to determine whether the individual presenting was exempt from these guidelines due to social vulnerability. Access to care would become essentially means-tested, and to require that someone disclose their financial situation or hardship in order to obtain a prescription is undignified.

Q2. Do you feel there is any further evidence we should consider in our proposals on the potential impact on health inequalities experienced by certain groups?

Yes. Logic would dictate that reducing access to medicines, whether for minor or chronic conditions, will only serve to increase health inequalities. We accept that logic alone will not stand, but we fail to see a robust impact assessment for the proposed changes, or any literature review on the health inequality gaps between countries which have differing policies on treating the minor ailments of their population.

There has been no mention nor impact assessment of the physical or psychological impact of leaving each of these minor conditions untreated, as some people with limited means will be forced to make this choice. Those with poor health literacy will also no doubt fall between the cracks of a system which would turn them away for self-selection of treatment, and may even come to harm if not given appropriate advice and support.

There will also be a loss of holistic care: it will become impossible to pick up patterns of ill health which could signal more serious underlying conditions e.g alternating bowel habit over a period of time may suggest bowel malignancy. Only repeated access to a healthcare professional (whether or not treatment is given) allows for this.

Q3. Do you agree with the three proposed categories for [items] or [conditions] as below:
• An item of low clinical effectiveness, where there is a lack of robust evidence for clinical effectiveness;
• A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own; or
• A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy

No.

We agree with category 1, as clinical effectiveness must underpin modern care and value-based medicine. However, as new evidence becomes available, it must be assessed and taken into account as soon as is possible.

We disagree with category 2, for several reasons. All health conditions require medical advice, regardless of whether treatment is given. This is a key component of the Scottish Minor Ailments Service, where following a consultation there are three possible outcomes: advice only, treatment or referral. There is no incentive for prescribing so Pharmacists are able to give the most appropriate advice and education in a format suitable for the individual seeking care. This would not be possible in a supermarket or petrol station. We also note with concern that NHS England is content for its patients to suffer the symptoms of a condition for its duration – this in itself may be enough to affect an individual's mental health or indeed productivity if they are unable to work due to distressing symptoms.

For example, although treatment for an acute sore throat may not address the root cause it may allow a person who has to talk in the course of their working day to remain in work for the 3-10 days that their condition persists. There is also a concern that as the public's behaviour is changed such that they no longer seek advice on these conditions, unless they have internet access and reasonable literacy, it will become more challenging to educate on general self-care and preventative measures, potential "red flag" symptoms or expected duration of self-limiting illnesses. It is impossible to provide a worsening statement to a person if they are never assessed.

We are also concerned with how category 3 has been described. Moving towards self-care of minor ailments is a reasonable goal for any healthcare system to set, however it is only by advocating supported self-care that we can ensure equality of health for our population. If these changes are implemented, there are those who will have to choose between, for example, food and medication for a minor ailment. We recognise that many medications are available at low cost in supermarkets and other outlets, but these come without the advice and support of a healthcare professional such as a pharmacist. Those with poor literacy or health literacy may not even manage to select an appropriate product for their condition or which does not interfere with other medication or health issues. Ibuprofen is a well-established drug but is also part of a group of medicines which cause the most unplanned emergency hospital admissions as a result of improper use. We also believe that should these proposals go ahead, there will be a significant and unnecessary increase in workload for primary care staff unless NHSE carries out a robust and continuing training programme

to educate frontline staff on responding to symptoms and current product licenses. Patients who are told to purchase medication at a pharmacy but are not suitable under OTC licenses will experience a quadruple journey (e.g. present at GP, sent to pharmacy for self-care, product unsuitable, directed back to GP, prescription generated, return to pharmacy for dispensing). Not only is this frustrating for patients, it is highly inefficient for the health service. Again, a national minor ailments service can reduce patient interactions to a single visit for most conditions, and would still represent a cost saving compared to a GP appointment.

Q4. Do you agree with the general exceptions proposed?

No. As above, product licenses may not allow treatment for many individuals, and if selecting from a supermarket or other outlet on the advice of a GP then a patient would not even be aware that they were taking a medicine on an unlicensed basis and would have no cause for recourse should there be an unexpected adverse event. We would also reinforce our statement that a rolling education programme on product licenses would be required to avoid circuitous patient journeys.

We do not believe that a clinician has or should have the appropriate information to make a judgement on whether a person is socially vulnerable or not. This may be the case entirely due to their financial situation and this would not be apparent to the prescriber in the course of a consultation nor should the person have to volunteer the information or have it asked of them.

Q5. Should we include any other patient groups in the general exceptions

Yes. Although it would be ideal to open up NHS access to these treatments via community pharmacy for all, at a minimum those who are exempt from prescription charges should still be able to have these items prescribed in primary care. They represent the most vulnerable groups in our society and as such should have their right to healthcare free at the point of delivery protected before others if it has to be eroded at all.

Q6. Section 1: Drugs with limited evidence of clinical effectiveness Do you agree with the recommendation to: Advise CCGs to support prescribers in advising patients that [item] should not be routinely prescribed in primary care due to limited evidence of clinical effectiveness?

a) Probiotics – Yes.
b) Vitamins and minerals – Yes.

Q7. Section 2: Self-Limiting Conditions Do you agree with the recommendation to: Advise CCGs to support prescribers in advising patients that a prescription for treatment of [condition] should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment?

a) Acute sore throat – No. Just because a sore throat will clear up on its own does not mean that a person must suffer the symptoms.

These may be such that a person cannot work, depending on their occupation. Those on low income may not be able to afford symptomatic relief and as such would have no choice but to stay off work, reducing productivity and causing distress. We are also concerned that as the public psyche shifts to not approaching healthcare professionals for advice, those with poor health literacy may not realise that their sore throat could be as a result of e.g. serious side-effect of another medication or a sign of another condition deteriorating.

b) Cold sores – No. Aciclovir cream can be inexpensive, but this is entirely dependent on what is available near where the patient lives and works. Although this ailment is self-limiting, there are circumstances where it is desirable to speed up recovery by using treatment and a cost barrier should not be introduced in these cases. For example, some would find having a cold sore emotionally distressing. In addition, Herpes Zoster can cause serous complications in the very young and as such any new mothers or their families should have free access to treatment to allow bonding with baby to resume as soon as possible.

c) Conjunctivitis – No. This consultation actually acknowledges that only half of all conjunctivitis cases clear on their own. By allowing these strains to be left untreated along with the self-resolving ones, it would exponentially increase the opportunity for microbe transmission and thus the number of people who would have to purchase treatment which can be expensive. If this proposal goes ahead unchanged, preparatory work will need to be done with nurseries and schools to ensure that attendance rates do not drop as incidence increases and

pupils are permitted to stay in education whilst they wait to find out whether they will need treatment or not.

d) Coughs, colds, nasal congestion – No. Again, these conditions may clear up of their own accord but those who cannot afford or do not have the ability to select appropriate treatments for symptom control will suffer reduced productivity, as will the businesses and organisations they work for. We believe it is unethical that a significant section of our society has a much worse experience of common viral conditions solely due to their ability to fund treatment.

e) Cradle cap – Yes, although the psychological effect of leaving this untreated on new mothers must be taken into account.

f) Haemorrhoids – No. Again, we disagree with NHSE's view that symptom control has no value. There are those for whom the discomfort experienced would be such that they stayed off work if unable to afford treatment.

g) Infant colic – No. Although the evidence base is weak this is due to a lack of available robust studies rather than a conclusive determination against the agents used. The psychological effects on parents and guardians of having a child in near-constant distress is significant, as is the effect of not being able to intervene in any way.

h) Mild cystitis – Yes. As long as an assessment is carried out by a qualified healthcare professional to ensure that the symptoms are mild and no treatment is the correct advice to give. In Scotland, there is a national PGD which allows Pharmacists to assess patients presenting

with UTI symptoms and either give advice only, treatment under a PGD or a referral. This has shown cost-effective triage, effective antimicrobial stewardship and positive outcomes for patients without the need for a prescription or GP intervention in a significant proportion of cases.

Q8. Section 3: Minor Ailments Suitable for Self- Care
Do you agree with the recommendation to: Advise CCGs to support prescribers in advising patients that a prescription for treatment of [condition] should not routinely be offered in primary care as the condition is appropriate for self-care?

a) Contact dermatitis – No. Contact dermatitis affects people in different ways and to differing extents. Proper use of emollients to treat and prevent flare-ups can require large volumes of product to be applied frequently, which would come at significant cost to the individual. In addition, over-the-counter topical corticosteroids have restrictive licenses which limit both the area of skin and location of any flare-up which can be treated, the patient groups who can use them and treatment duration. A considerable amount of work would need to go into educating health professionals and the public in order to avoid poor patient experience and unnecessary duplication of effort for the NHS.

b) Dandruff – No. This may well be classed as a minor ailment, but it is also a long-term one. Products with known efficacy are expensive and many would choose not to purchase these. Distress as a result of untreated dandruff can be significant, and would not be picked up if an individual was self-selecting products in a non-healthcare outlet.

c) Diarrhoea – No. Treatment varies in cost and appropriateness depending on the cause of the symptoms. Without oversight by a practitioner, patterns of ill health signifying more serious underlying problems will be missed. Although all packs have dosing instructions and worsening statements, these are relatively complex and may not be understood by those with poor health literacy which could lead to undue suffering and deterioration. We also cannot ignore the potential effect on productivity for those who cannot afford medication which counteracts symptoms.

d) Dry eyes – No. This is another condition which is minor but long-term for many. A single bottle of lubricating eye drops is inexpensive, but to prevent infection they must be discarded 28 days after opening and a bottle per eye is recommended. This would make the cost of ongoing treatment prohibitive for those living in poverty. Yet again, the psychological and productivity cost of leaving dry eye untreated must be considered in making this decision.

e) Earwax – Yes. However, assessment must still be made to ensure that this is indeed the cause of symptoms.

f) Hyperhidrosis – No. The treatments available for this are expensive and the condition is long-term. This condition in particular can have a profound effect on an individual's confidence and mental wellbeing.

g) Head lice – No. Wet combing requires strict adherence to a schedule of action every two days for a fortnight, which can be difficult to achieve – particularly with children. The alternative of using a head lice treatment is more often successful, but is also expensive, especially if

dealing with long hair or more than one individual. Some would be forced to choose to go without treatment, risking transmission and the social stigma attached to infestation which can be upsetting.

h) Indigestion/Heartburn – No. We are concerned about undifferentiated diagnoses and how these would be picked up once the public psyche has shifted to selecting self-care products in the first instance instead of approaching a healthcare professional to describe their symptoms. It is not uncommon for heart attacks to present with similar symptoms to indigestion or heartburn, and there are oter warning signs which are not included in the product information e.g. first experience of symptoms in over-40s is unusual.

i) Infrequent constipation – No. What would the definition of "infrequent" be? Each individual will have a different interpretation based on their own experience and there is the risk of missing patterns of ill health. The products available for treating constipation can be expensive.

j) Infrequent migraine – No. Not only are 5HT-1 receptor antagonists (Triptans) expensive, there are few available for purchase and where one treatment may work for one individual, another product may be needed for a different person with the same symptoms. The licensing restrictions on these for sale in a pharmacy are also restrictive and would need to be well known before directing patients to community pharmacies.

k) Insect bites and stings – Yes. However, an exception should be added for children and vulnerable adults as treating the symptomatic

itch is the only way to avoid entering an itch-scratch cycle in those who have poor impulse control and understanding. This can lead to skin breakage and subsequent infection.

l) Mild acne – No. Acne is as mild or severe as the person who is experiencing living with it perceives it to be, and evidence-based treatment should be available on the NHS for all classifications of this long-term condition. The effect on mental health of excluding those who cannot afford treatment from a way to improve the appearance of their skin would be serious and lasting.

m) Mild dry skin/Sunburn – No. Principally these two conditions should not be bundled together. Sunburn is short-term and we agree that it is suitable for supported self-care. Mild dry skin, on the other hand, is a long-term condition which requires great quantities of emollient applied frequently to control, and backup corticosteroids in a range of strengths to manage properly. Cost and availability of over-the counter options should prohibit this condition from being one suitable for patients to bear the cost of.

n) Mild/moderate hayfever – No. Whilst the treatments for hayfever can be inexpensive, treatment is dependent on how each individual responds to each medication so would create potential health inequalities where those who do not respond to "low-cost" options may not have the means to afford treatment with other agents which are available OTC at a higher cost. As such, these should be available on prescription or as part of a minor ailments scheme.

o) Minor burns/scalds – Yes. These should always be assessed but we accept that dressings (if appropriate) are low cost and widely available, and the likelihood of complication is low for these conditions.

p) Minor pain, discomfort and fever – No. The range of pharmaceutical options and associated costs is wide and challenging to navigate for those with poor health literacy. Again, we raise concern for the inevitable harm which will come once there is a shift to patients self-selecting products from outlets other than pharmacies when they experience pain. Improper use of NSAIDs is associated with a relatively high risk of unplanned hospital admission and should be recommended only as part of a consultation. Symptom control for extended periods of time will bring a cost which not all will be able to meet, which will have a knock-on effect on productivity and mental wellbeing.

q) Mouth ulcers – Yes. However, we must again raise a concern around the direction of travel to patients self-assessing and selecting treatment. Basal cell carcinoma and herpetiform ulceration are easily missed.

r) Nappy rash – Yes.

s) Oral thrush – No. The product available for this indication has stringent licensing restrictions which prevent use in the young and in those on certain medications. It is also relatively expensive to purchase and some would choose not to do so, suffering the symptoms for longer than is necessary.

t) Prevention of dental caries – No. Cost would be a barrier to a significant number of people, and neglecting to use the clinically proven agent would lead to a deterioration in oral health. There is a clear link between oral health and many other conditions such as heart disease, so the wider unintended consequences of removing these items from prescription supply must be seriously considered. We would argue that this should be a factor when assessing the cost-effectiveness of this particular intervention.

u) Ringworm/athlete's foot – No. The cost of treatment varies but can be expensive, which could lead to spread of disease and complications.

v) Teething – No. For those who could not afford treatment, their children would experience unnecessary pain and discomfort. These parents' mental health and productivity may also suffer as a result of distress, helplessness and lack of sleep.

w) Threadworm – No. The entire family must be treated, which can make the cost of the OTC products prohibitive for those with low incomes.

x) Travel sickness – No. The severity and frequency of occurrence must be taken into account. It is reasonable that people purchase product for infrequent use, but the cost of preventing travel sickness which someone is exposed to daily (e.g. on a commute) is much higher and some will not have the means to do so.

y) Warts and verrucae – Yes. However, the wider cost of increased transmission must be considered. This would occur where people

afford treatment and choose to go without. Spread to other people or to other areas on the same person is associated with greater treatment cost and potential complication.

Q9. Are there any item or condition specific exceptions you feel should be included, in addition to those already proposed and the general exceptions covered earlier?

We believe that we have covered our concerns in our responses to the above questions. In general, we feel that cost efficiencies can be made by shifting the balance of care to another setting such as community pharmacy and therefore making significant administrative savings rather than focussing on item cost, as each of these conditions should be treatable on the NHS for those who require it. This would retain the invaluable assessment and advice service and would have either zero or a net positive effect on outcomes.