Views on NHS England’s guidance on OTC prescribing

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In March 2018, NHS England and NHS Clinical Commissioners published guidance on conditions for which over-the-counter (OTC) items should not routinely be prescribed in primary care. This article examines some of the feedback received during the consultation process and how the final guidance has been refined.

In 2005, Norman Cousins wrote: “The doctor knows that it is the prescription slip itself, even more than what is written on it, that is often the vital ingredient for enabling a patient to get rid of whatever is ailing him.”[^1] If that is what they believe, some doctors might have to reconsider their prescription writing practices in the light of recent new guidance.

In July 2017, NHS England and NHS Clinical Commissioners launched a consultation on items which should not routinely be prescribed in primary care, so-called “low clinical value” treatments, including omega-3 fatty acids and homeopathy, and final guidance for CCGs was issued in November 2017.[^2] This was closely followed by a consultation on conditions for which over-the-counter (OTC) items should not routinely be prescribed in primary care (see Table 1) and the final guidance for this was published in March 2018.[^3]

NHS England said that in the year to June 2017, around £569 million came out of NHS funds to pay for prescriptions for medicines that could have been bought OTC from a pharmacy or other outlet such as a petrol station or supermarket, often at a lower cost than that incurred by the NHS. These prescriptions included items for minor conditions that would respond to self-care or cure themselves and items for which there was limited evidence of clinical efficacy.

The consultations and subsequent guidance were initially prompted by a request from NHS Clinical Commissioners, the organisation that represents Clinical Commissioning Groups (CCGs), to reduce the prescribing of ineffective medicines in primary care. This led to NHS England joining forces with NHS Clinical Commissioners to form a joint clinical working group with prescriber and pharmacy representatives from relevant national stakeholders in order to review the evidence base, co-

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ordinate a public consultation process and produce a consistent, national framework of commissioning guidance.

The long-term aim was to help CCGs use their prescribing resources more effectively and deliver better outcomes from their medicines for their patients. By reducing spending on the treatment of self-limiting conditions, the resources could be used for higher priority areas with a greater impact on patients, to support improvements in services and ensure the NHS’s long-term sustainability, explained NHS England. CCGs, however, must make their own decisions on the impact of local implementation of the guidance, and their legal duties to advance equality and have regard to health inequalities.

Consultation feedback

However, John Kell, Head of Policy at the Patients’ Association, is concerned about the lack of patient engagement in developing the initial proposals. He says: “We felt that patients should have been in the process from the start. The proposals were drawn up by a committee of doctors and we were told that patients’ views had been represented by the doctors. That is not how patient engagement works.”

Mr Kell thinks that patients have a vital contribution to make to ensure their situation is given due weight and is represented accurately in the guidance. He firmly believes there should have been full patient engagement throughout the process. He says: “I think it would have helped if patients had been involved earlier to point out possible difficulties. I think patients can explain much more clearly what it is like to have healthcare needs and to access medicine. Straightforward as it would seem from the GP’s perspective, patients say GPs can appear too keen to preserve budgets, and at times even demand that patients ‘explain themselves’ before they will renew a prescription for a medicine that the patient has been taking to good effect.”

During the 12-week OTC consultation, from December 2017 to March 2018, the joint clinical working group considered evidence from organisations such as NICE, NHS Choices, the BNF and Public Health England and this time also heard from patients and their representative groups, members of the public, NHS staff, CCGs, Trusts, plus Royal Colleges, the pharmaceutical industry and others.

Responses arrived via an online survey, webinars, public events, letters and emails. The largest proportion of the 2616 respondents to the survey who indicated their respondent type were patients (33%), followed by: members of the public (24%), clinicians (17%), family and friends of patients (5%) and CCGs (5%). The survey included a combination of ‘open text’ questions, where respondents could write their views, as well as closed questions, where they ‘ticked’ their response to a set of graded pre-set options ranging from agree through to disagree, or unsure.

Key themes raised in the survey, correspondence, webinars and meetings are listed in the Consultation Report of Findings by respondent type. There was broad agreement on some issues highlighted as a concern by all the respondent groups. These included fears for the impact of the guidance on: health inequalities for people requiring considerable care, eg the disabled and the elderly, who would find it harder to access treatments; Black and minority ethnic communities; people from lower socioeconomic backgrounds; and those with existing long-term and/or chronic conditions, requiring large quantities of OTC medicines, who might not be able to afford them. Others raised concerns that there would be a potential impact on groups with low levels of health literacy, whose conditions might be missed or could worsen. A significant proportion of participants felt the changes would affect people with learning disabilities negatively.

Impact on rural practices

There was also a plea for consideration of the impact on rural populations without access to a local pharmacy. Matthew Isom, Dispensing Doctors Association (DDA) Chief Executive Officer, emphasised the special needs of people who live in an area without easy access to a pharmacist, and there are many people who fall into this category.

He says: “In country areas, there are 1200 GP dispensing doctors, who all have in common the fact that they are located where no local pharmacy is readily available to the community. This guidance shouldn’t have any impact on them because they have an obligation to their patients under

### Table 1. Self-limiting and minor conditions, and items of limited clinical effectiveness, included in the final NHS England guidance on conditions for which over-the-counter items should not routinely be prescribed in primary care

- Probiotics
- Vitamins and minerals

**Self-limiting conditions**
- Acute sore throat
- Infrequent cold sores of the lip
- Conjunctivitis
- Coughs and colds and nasal congestion
- Cradle cap (seborrheic dermatitis – infants)
- Haemorrhoids
- Infant colic
- Mild cystitis

**Minor conditions suitable for self-care**
- Mild irritant dermatitis
- Dandruff
- Diarrhoea (adults)
- Dry eyes/sore tired eyes
- Earwax
- Excessive sweating (hyperhidrosis)
- Head lice
- Indigestion and heartburn
- Infrequent migraine
- Insect bites and stings
- Mild acne
- Mild dry skin
- Sunburn due to excessive sun exposure
- Sun protection
- Mild to moderate hay fever/seasonal rhinitis
- Minor burns and scalds
- Minor conditions associated with pain, discomfort and/or fever
- Mouth ulcers
- Nappy rash
- Oral thrush
- Prevention of dental caries
- Ringworm/athlete’s foot
- Teething/mild toothache
- Threadworms
- Travel sickness
- Warts and verrucae

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the NHS GP contract to supply medicines where they consider there to be a clinical need. However, our members have reported some pressure from CCGs to conform to the wider guidance and reduce their prescribing of these items (and thus the associated costs). This is obviously unfair because our members can’t do anything about it as there is no pharmacy readily available for them to refer their patients to.

“It’s important that CCGs understand the unique situation of dispensing doctors because there is a danger that their practices start to look a bit like outliers – it needs to be taken into consideration that there is a good reason for their prescribing figures – they are not just ignoring the recommendations to refer their patients to the local pharmacy, because there is no pharmacy within 1.6km of their patients’ registered residence.”

Mr Isom concludes: “We are pleased to have represented our members during the consultation relating to the guidance. We have unique needs; we have a much older demographic, who obviously use their doctors much more often and have specific clinical requirements. We think all guidance should be rural-proofed before it is issued.”

NHS England listened to the DDA’s feedback and in the final OTC guidance, issued in March, included a note under the ‘general exceptions’ heading that states: “CCGs will also need to take account of their latest local Pharmaceutical Needs Assessment (PNA) and consider the impact of this guidance on rural areas and access to a pharmacy and pharmacy medicines.”

**Encouraging self-care**

Dr Andrew Green, BMA Council and General Practitioners Committee (GPC) UK clinical and prescribing policy lead, who sat on the committee that produced both sets of guidance, saw at first hand the processing of information collected from a wide-ranging set of respondents. He says: “I think both of these policies have landed softer than was feared and in fact amended their original conditions to try to make the policies workable – and that is to be very much welcomed.

“In fact, from my point of view, I think both these documents largely reflect the ways that GPs were working in any case. For example, we already recognised the importance of self-care, of patient education and of encouraging patients to use community pharmacies for everyday medical problems. So having this written into a document was no surprise to GPs and fitted into the way most of us worked anyway – we already encouraged people to buy OTC medicines where possible. What we do say to patients are things like ‘Well, you’ve got hay fever, you can treat this with loratadine from the chemist,’ and nine out of 10 patients will say ‘Thank you very much,’ and that’ll be the end of it. If a patient then asks you for an FP10, there is no doubt you are contractually obliged to supply that.”

However, he adds a note of caution on directing patients to the pharmacy or the supermarket to buy their OTC medication, saying: “There were two main drivers to this work: undoubtedly there is a wish to cut the costs of drugs to the NHS – and at first sight spending NHS money on things that are available OTC would appear to be wasteful – but in fact many of these drugs are used for chronic and severe conditions for which NHS care is appropriate. So, for instance, although antihistamines are used for minor insect bites, they are also used for serious long-term allergies for which NHS treatment is appropriate and current data collection does not let us unpick this.”

Dr Green adds: “If the NHS is to continue to provide comprehensive care, it is important for everyone to self-care wherever possible, and for the time-rich cash-poor members of society, the provision of free prescriptions may act as a magnet to the surgery. However, the current wording of the regulations under which GPs work allows them to encourage self-care but not to refuse a prescription for a treatment that has been recommended.”

What would he say to those who have interpreted this as a ‘ban’ on prescribing? Dr Green replies: “I think it’s important that everyone does actually read the documents. One of the things that’s very clear is that this is for acute conditions only and not for long-term issues, and that GPs retain the right to prescribe where it can be justified. I think people have read into the documents what they fear might be there rather than what is there. So the idea that we should not be prescribing for long-term conditions is completely wrong. It is very specific that it is for short-term conditions only, so people who need, for example, long-term analgesics, should continue to have those prescribed by the GP. The BMA argued that there were very real dangers in ‘banning’ prescriptions for things like ibuprofen or paracetamol because the danger is that more powerful drugs with more side-effects would then be prescribed as an alternative, and that view was accepted by NHS England.”

**Refinements to the guidance**

The final guidance on OTC prescribing remains largely unchanged from the draft guidance published in December 2017, says NHS England, but there are some important “refinements and clarifications” as a result of the feedback received during the consultation process. These include general exceptions to the guidance in certain scenarios where patients should continue to have their treatments prescribed. For instance, for the treatment of more complex forms of minor illnesses, eg severe migraines that are unresponsive to OTC medicines, and for patients whose symptoms suggest the condition is not minor, ie those with red flag symptoms (eg indigestion with very bad pain).

General exceptions that apply to the recommendation on self-care include one that says: “When implementing this guidance, CCGs will need to supply patients with further information on signposting so that they are able to access the right service.” The guidance also notes that being exempt from paying prescription charges does not indicate automatic exemption from the guidance, but is granted to individual patients where the clinician considers their ability to self-manage is compromised as a consequence of medical, mental health or social vulnerability. Some minor/self-limiting conditions also have specific
listed exceptions, eg the clinical working group agreed that the description for cold sores should be amended to clarify that OTC items should not be routinely prescribed for “infrequent cold sores of the lip” (see Table 1), and the instruction on cradle cap should be refined to include the specific exception: “if causing distress to the infant and not improving”.

One of the suggested recommendations for implementation in the Consultation Report of Findings⁴ says: “GPs should be trusted and supported to work within the spirit of the guidance, rather than given detailed didactic prescriptive mandates from commissioners.” It would be reasonable to display a prompt if a certain drug was entered into the system but not acceptable if this made it difficult or impossible to prescribe, it concludes. The guidance itself incorporates this recommendation, in its stress on the importance of the clinician’s judgement of patients’ needs when interpreting the guidance. One such statement, included in the general exceptions to the guidance, says that patients should continue to have their treatments prescribed in “circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.”

Perhaps 2018 will see doctors re-examining their attitude to recommending self-care rather than automatically writing prescriptions for their patients, as Norman Cousins described 13 years ago.

References

Declaration of interests
None to declare.

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