1. Background and Context

1.1. Coventry and Warwickshire Integrated Care Board (ICB) is reviewing how gluten-free (GF) foods are prescribed for adults and children who have been diagnosed with coeliac disease or dermatitis herpetiformis. Prescriptions for GF foods cost the NHS more than it costs to buy them directly in the shop, through a combination of clinician time, dispensing fees, and delivery charges. Currently the ICB spends £240,000 per year on prescription of GF foods and the current CWICB policy restricts prescribing to bread and mixes, capped at 8–10 units per month.

1.2. In 2017, the Department of Health & Social Care conducted a public consultation which led to legislative changes restricting GF prescribing to a limited list of items (bread and flour mixes) under the NHS Drug Tariff. The NHS England guidance (2018) empowers ICBs to further restrict or fully decommission GF prescribing, provided they consider their legal duties around equality and health inequalities.

1.3. Across England, approximately one-third of ICBs have decommissioned GF prescribing, including all East Midlands ICBs and several in the West Midlands (e.g. Hereford & Worcestershire, Shropshire, Telford & Wrekin). Staffordshire and Stoke ICB have retained prescribing only for children under 18. This regional shift reflects a growing consensus that GF prescribing is not clinically essential, given the wide availability of GF products in supermarkets and the existence of naturally GF alternatives (e.g. rice, potatoes).

1.4. As part of the ICB prioritisation process to assess value for money commissioning the ICB has reviewed the case for continuing to provide GF foods on prescription.

2. Evidence Base and Impact Assessment

2.1. Population Need

Coeliac disease affects approximately 1 in 100 people, though local population health management data does not provide a precise figure for Coventry and Warwickshire. Between November 2024 and January 2025, 1401 patients received gluten-free (GF) prescriptions, including 219 children.

When assessing need it is important to note that GF foods are not a “treatment” for coeliac disease in the way that medicines are. Prescribing of GF foods was originally introduced as GF foods were not easily available in supermarkets, making it much harder to adhere to a gluten-free diet. However, GF foods are now commonly available compared to 10 years ago, reducing the population need for foods to be supplied through prescription.

2.2. Health Impact

The Department of Health & Social Care (DHSC) impact assessment concluded that adherence to a GF diet is multifactorial, influenced by education, motivation, and access, not solely by prescription availability. Adherence rates among adults with coeliac disease range from 36–96%. **No significant adverse outcomes have been reported in ICBs that have already decommissioned GF prescribing**. In addition, no research literature has linked any adverse health outcomes to cessation of GF food prescribing.

Patients who do not follow a GF diet are at increased risk of complications such as osteoporosis, ulcerative jejunitis, and intestinal malignancy. However, naturally GF foods and retail options remain accessible, mitigating health risks for most patients.

2.3. Health Inequalities

A national equality impact assessment found that risks associated with decommissioning GF prescribing were largely mitigated by the availability of naturally GF foods and retail access. Prescribing data across Coventry and Warwickshire shows no correlation between deprivation and prescribing rates, suggesting that prescribing is driven by clinical diagnosis rather than socioeconomic factors.

Concerns were raised during engagement about affordability and access for individuals, particularly for vulnerable groups. See Section 3 for further details.

2.4. System Financial Impact

While GF foods are more expensive for individuals to purchase when compared to gluten-containing equivalents, the cost of GF products to the NHS via NHS prescription is even higher due to clinician time, dispensing fees, and delivery charges.

If gluten-free foods were to be fully decommissioned, this is projected to deliver annual savings of £240,000. These savings can be reinvested into areas of greater clinical need. The proposal does not require additional funding, technology, or infrastructure, and will reduce GP appointments and pharmacy dispensing time, thereby improving system productivity.

3. Patient and stakeholder engagement

3.1. As part of the engagement process, Coventry and Warwickshire ICB conducted a survey following approval from Finance & Performance Committee. The survey was widely promoted amongst people who are living with coeliac disease and a total of 232 responses were received, including submissions from local GPs, Coeliac UK and UHCW dietetics teams.

3.2. A full report detailing the responses to the engagement are included with this paper in Appendix A. However, the key themes from the survey are set out below:

3.2.1. **Affordability and Cost of Living**

The most dominant theme was concern over the increased cost of GF foods, which are estimated to be 35% more expensive than standard equivalents. Respondents feared that removing prescriptions would exacerbate financial pressures, particularly for those on fixed incomes, facing deprivation, or relying on food banks. Several responses emphasised the importance of GF prescriptions for children, particularly for school lunches and social inclusion. There was support for means-tested support, such as voucher schemes or subsidy cards, with references to the Welsh model and Luton ICB's pharmacy-led approach.

3.2.2. **Dietary Adherence**

Many respondents, including clinicians and advocacy groups, expressed concern that

decommissioning could lead to reduced adherence to a GF diet, especially among lower-income households, students, carers, and pensioners.

3.2.3. **Product Availability and Quality**
Concerns were raised about the availability and quality of GF products in retail settings, with some noting that brands perceived to be prescription only (e.g. Juvela, Glutafin) are not easily accessible or equivalent in taste and nutrition.

3.2.4. **Health Inequalities and Equity of Access**
Respondents highlighted potential impacts on Core20PLUS5 populations and inconsistencies in prescribing practices.

3.3. Although the majority of respondents expressed concerns about the removal of Gluten Free foods on prescription there was a minority who expressed their feeling that gluten free foods should be removed. Their reasoning was primarily centred around the availability of gluten-free foods on prescription, the need to prioritise NHS resources for those with greatest needs, equity with other dietary needs who do not receive food on prescription (such as lactose-intolerance) and waste / inefficiency in the current model.

3.4. The most frequently requested support to manage a gluten-free diet without NHS prescriptions is information about affordable gluten-free alternatives (28%), followed by dietitian advice and help with reading food labels. Many respondents also express a need for financial support or vouchers to offset the higher costs and there were many requests that other models are explored if products are removed from prescription.

4. Consideration of the themes of the engagement

4.1. Following the engagement the ICB considered the themes within the engagement and what risk they posed to the population, should the decision be taken to stop the prescribing of gluten-free foods.

4.1.1. **Affordability and Cost of Living**
It is recognised that GF are more expensive than basic supermarket alternatives, research suggests this additional costs to individuals would be about £11-£14 per month. However, when prescriptions were introduced for gluten-free foods it was in recognition that gluten-free foods were unavailable or very difficult to purchase, not as a subsidy against food costs for those of those who are living with coeliac disease. It is recognised that GF foods are more expensive, but the NHS prescription system is designed to meet clinical need, not to subsidise food costs. The NHS does not provide foods for other patient groups with allergies or intolerances.

Although the majority of respondents in the survey self-identified as having limited financial resources, prescribing data across Coventry and Warwickshire shows no correlation between deprivation and prescribing rates, suggesting that prescribing is driven by clinical diagnosis rather than socioeconomic factors.

Naturally occurring gluten free alternatives (e.g. rice, potatoes, corn flour) are available, affordable and widely understood.

4.1.2. **Dietary Adherence**
Although concerns were raised about the potential lack of adherence if foods were not available on prescription there is no published data to directly link adherence rates to prescription availability is available. Adherence rates among adults with coeliac disease range from 36–96% and no significant adverse outcomes have been reported in ICBs that have already decommissioned GF prescribing. No evidence was presented that linked any adverse health outcomes to GF foods not being available on prescription.

4.1.3. **Product Availability and Quality**
Current prescription brands were perceived to be prescription only (e.g. Juvela, Glutafin) are not easily accessible or equivalent in taste and nutrition, however it should be noted that both the brands referenced are available to purchase online without a prescription.

4.1.4. **Health Inequalities and Equity of Access**
Prescribing data showed no correlation between deprivation and prescribing rates, suggesting clinical diagnosis is the primary driver

5. Considering the options for Gluten Free Prescribing

5.1. Following the findings of the engagement and other research, the ICB considered the four possible options for GF prescribing

- **Option 1: Retain the status quo**
  This would maintain GF prescribing at the costs of £240k per year.

- **Option 2: Restrict to patients with financial hardship only**
  Means-tested support such as voucher schemes or subsidy cards do exist in Wales and Luton ICB. In the Welsh model gluten free food vouchers are funded by local government. In the Luton scheme pharmacies are commissioned to check eligibility of patients based on the receipt of certain benefits.

- **Option 3: Restrict to children only**
  This is more feasible and easier to administer than option 2 but would not be means tested.

- **Option 4: Decommission GF prescribing completely**
  This would remove all gluten-free items from prescription

5.2. These options were all considered by a meeting of the Senior Leadership Team at the ICB which includes a mix of commissioners and clinicians

- **Option 1: Retain the status quo**

This was considered to represent a relatively poor value for money investment and does not result in any meaningful health benefit for our population.

- **Option 2: Restrict to patients with financial hardship only**
  A scheme which is based on financial hardship would move costs to the Local Authority, who already have local and national schemes in place to support those who are suffering from financial hardship. Setting up and administering a new scheme through local government would add additional cost pressures.

  SLT considered whether restricting prescribing to people with certain financial circumstances/benefits payments would be feasible through the NHS (administered by Primary Care). They concluded that whilst technically possible it would be cumbersome to administer and the resulting financial costs would mean any financial savings would be materially eroded to the point of making the overall savings from such a scheme of marginal benefit. There is also no other precedent for this for any other prescribable item.

- **Option 3: Restrict to children only**
  It was agreed that is more feasible and easier to administer through Primary Care than option 2. However, the reason to continue to prescribe to children would solely be on the basis of financial impact to affected families, not for any health benefit. SLT discussed whether making judgements on the provision of NHS services on the basis of financial impact on patients was a sound principle. In conclusion SLT decided that this was not within the remit of clinical prescribing as the NHS prescription system is designed to meet clinical need, not to act as a mechanism for food provision or income support.

- **Option 4: Decommission GF prescribing completely**
  SLT considered that there is no evidence that ceasing prescribing gluten free foods has any demonstrable health impact and therefore it represents poor value for money. A move to decommission gluten free foods would be in line with many other ICBs including Herefordshire and Worcestershire, our local partners. There is also no evidence that current prescribing is related to deprivation or have a direct impact on health inequalities. It would reduce low value prescribing activity in General Practice and community pharmacy

5.3. Following the consideration of these options SLT agreed that the preferred option, which will be recommended to Finance and Performance Committee was that GF prescribing was decommissioned completely.

6. Support available if gluten free prescribing is decommissioned / restricted

6.1. It is important to note that no final decisions have been made on the future of gluten free prescribing. However the ICB has considered that, if gluten free prescribing was to be decommissioned, what mitigations would need to be put in place to support those currently in receipt of prescription, and those who will be diagnosed in the future.

6.2. Affordability and the difficulty of adhering to a gluten free diet were the key issues raised throughout the engagement and, if decommissioning were to go ahead, the ICB will develop materials to support with signposting to dietetic support when needed and will share links on the ICB website. In addition, additional information will be provided to GPs on the support available for those who may be suffering from financial hardship, including food banks and local authority support.

6.3. The savings from decommissioning GF prescriptions may be able to be recycled into prevention programmes as has previously been agreed and would be arranged on a system basis (although a final decision on this is dependent on wider financial considerations)

6.4. Monthly prescribing data will be monitored to track compliance and identify any anomalies or unintended consequences. Practices will be supported to manage patient queries and concerns, particularly for those with complex dietary needs or socioeconomic vulnerabilities.

6.5. Where necessary, patients can be referred for dietetic support to ensure safe and effective dietary adherence post-decommissioning.

6.6. Any changes would be communicated to patients via their GP Practices. Prescriptions would not be stopped immediately following any decision, but a transition period would be put in place to help people to understand the alternatives available and access support where appropriate.

7. Decision making and next steps

7.1. The ICB has completed an Equality Impact Assessment and worked with local stakeholders and patients to understand what the impact would be on changing gluten free prescribing. It has also investigated the plausibility of other models or restricting prescribing to certain groups, as per the feedback in the consultation.

7.2. Representatives of the ICB are now attending Scrutiny Committees in both Coventry and Warwickshire to understand the views of the Committee and to ask if the Committee believe that sufficient engagement has taken place for the ICB to understand the impact of any potential change or if there is more work required.

7.3. Depending on the outcome of these conversations any further activities deemed necessary by the Committees will be undertaken. If the Committees are satisfied with the activities to date, a decision-making business case will be taken to the next Finance and Performance Committee for a final decision to be taken.

Members are asked to review the paper and associated engagement report and determine whether:

1. The Health and Social Care Scrutiny Board agrees that the information in the paper regarding the engagement undertaken, numbers of patients affected by the change and mitigations outlined are sufficient to go ahead with the proposed service change **OR;**

2. That the Board believes that this constitutes a major service change which requires further and wider public engagement to understand the impact of the change.