NHS Clinical Commissioners
The independent collective voice of clinical commissioning groups

NHS England

Items which should not routinely be prescribed in primary care: Guidance for CCGs

NHS England Gateway Publication 07448

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the recommendations set out in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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1 Background

1.1 Who is this guidance for?

This guidance is addressed to CCGs to support them to fulfil their duties around appropriate use of their resources. We expect CCGs to take the proposed guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties.

This guidance is issued as general guidance under s14Z10 and S2 of the NHS Act 2006 and is addressed to CCGs to support them to fulfil their duties around appropriate use of prescribing resources. The objective of this guidance is to support CCGs in their decision-making, to address unwarranted variation, and to provide clear national advice to make local prescribing practices more effective.

1.2 Why have we developed this guidance?

Last year 1.1 billion prescription items[1] were dispensed in primary care at a cost of £9.2billion[2]. This growing cost coupled with finite resources means it is important that the NHS achieves the greatest value from the money that it spends. We know that across England there is significant variation in what is being prescribed and to whom. Some patients are receiving medicines which have been proven to be relatively ineffective or in some cases potentially harmful, and/or for which there are other more effective, safer and/or cheaper alternatives; there are also products which are no longer appropriate to be prescribed on the NHS.

NHS England has partnered with NHS Clinical Commissioners to support Clinical Commissioning Groups (CCGs) in ensuring that they can use their prescribing resources effectively and deliver best patient outcomes from the medicines that their local population uses. CCGs asked for a nationally co-ordinated approach to the creation of commissioning guidance, developed with and by CCGs. The aim was a more equitable basis on which CCGs can take an individual and local implementation decisions. CCGs will still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

1.3 How have the recommendations in this guidance been developed?

In response to calls from GPs and Clinical Commissioning Groups (CCGs) who were having to take individual decisions about their local formularies, NHS Clinical Commissioners (NHSCC), the national representative organisation for CCGs, surveyed their members during February and March 2017 to assess views as to

[1] An item is anything which can be prescribed on an NHS prescription. More information on what is prescribed on an NHS prescription is available in the Drug Tariff.
[2] NHS Digital Prescription Cost Analysis 2016

whether a range of medicines and other products should be routinely available for prescription on the NHS.

NHS Clinical Commissioners asked NHS England to work with them to produce commissioning guidance to support their member organisations in taking decisions about prescribing of these products in primary care.

Together, NHS England and NHSCC established a clinical working group, chaired by representatives of these two organisations, with membership including GPs and pharmacists, CCGs, Royal College of General Practitioners, National Institute for Health and Care Excellence (NICE), Department of Health, the Royal Pharmaceutical Society and others (full membership listed at appendix A). This clinical working group was tasked with identifying which products should no longer be routinely prescribed in primary care.

Work focused on developing guidelines for an initial list of eighteen products which fall into one or more of the following categories:

- Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns;
- Products which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation; or
- Products which are clinically effective but, due to the nature of the product, are deemed a low priority for NHS funding.

The group assigned one or more of the following recommendations to products considered:

- Advise CCGs that prescribers in primary care should not initiate {item} for any new patient;
- Advise CCGs to support prescribers in deprescribing {item} in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change;
- Advise CCGs that if, in exceptional[3] circumstances, there is a clinical need for the item to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional;
- Advise CCGs that all prescribing should be carried out by a specialist; and/or
- Advise CCGs that this item should not be routinely prescribed in primary care but may be prescribed in named circumstances such as {item}.

In reaching its recommendations for the 18 products listed in this guidance document, the group considered recommendations from NICE, where relevant, in

[3] In this context, “exceptional circumstances” should be interpreted as: Where the prescribing clinician considers no other medicine or intervention is clinically appropriate and available for the individual

order to support CCGs in implementing NICE guidance across the country; in particular it identified items which NICE consider to be "Do not do's[4]".

Where NICE guidance was not available the group considered evidence from a range of sources, for example; the Medicines and Healthcare products Regulatory Agency (MHRA), the British National Formulary, the Specialist Pharmacist Service and PrescQIPP Community Interest Company (CIC) evidence reviews.

The group reviewed each product against the following criteria:

- **Legal Status** i.e. is it prescription only, or is it available over the counter in pharmacies and/or any retail outlet?
- **Indication** i.e. what condition is it used to treat?
- **Background** i.e. a general narrative on the drug including. pack size, tablet size, whether administered orally etc.
- **Patent Protection** i.e. is the drug still subject to a patent?
- **Efficacy** i.e. is it clinically effective?
- **Safety** i.e. is the drug safe?
- **Alternative treatments and exceptionality for individuals** i.e. do alternatives exist and if so, who would they be used for?
- **Equalities and Health Inequalities** i.e. are there groups of people who would be disproportionately affected?
- **Financial implications, comprising:**
    - **Commissioning/funding pathway** i.e. how does the NHS pay for the drug?
    - **Medicine Cost** i.e. how much does the drug cost per item?
    - **Healthcare Resource Utilisation** i.e. what NHS resources would be required to implement a change?
    - **Annual Spend** i.e. what is the annual spend of the NHS on this item?
- **Unintended consequences**

The group's recommendations on the 18 items within this guidance were publicly consulted on for a period of 3 months, from 21st July – 21st October 2017. During the consultation we heard from members of the public, patients and their representative groups, NHS staff, various Royal Colleges and the pharmaceutical industry, amongst others. Section 1.4 details the main findings from the consultation and the changes that have been made as a result of what we have heard. A more detailed report on the consultation can be found in *Items which should not routinely be prescribed in primary care: consultation report of findings* published alongside this guidance. The final recommendations set out in this guidance document reflect the outcome of the consultation. The potential equality impact of these recommendations has also been considered and is outlined in the Equality and Health Inequalities Impact Assessment document published alongside this guidance.

1.4 How have the recommendations in this guidance been developed following the results of the consultation?

We listened to what our stakeholders told us through the consultation and refined our draft guidance in light of the responses, discussion through webinars and the

[4] Practices NICE recommend should be discontinued completely or should not be used routinely

engagement exercises, as well as recommendations from the joint clinical working group which considered the feedback in detail.

Whilst overall the final guidance remains largely unchanged from the draft guidance published in July 2017, there have been some important refinements and clarifications made in respect of a number of products. Details of each product are as follows:

Co-proxamol – We received a significant number of responses during the consultation around co-proxamol and the safety of continuing to prescribe this treatment emerged as the main theme. As a result of what we heard, the joint clinical working group recommended that we keep our original recommendations.

Dosulepin – As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for dosulepin.

Prolonged-release Doxazosin - As a result of what we heard the joint clinical working group did not feel it necessary to amend the proposed recommendations on deprescribing for prolonged-release doxazosin; however the group felt that there would not be cases of exceptionality that would warrant referral to a multidisciplinary team so removed that recommendation.

Immediate release Fentanyl – During the consultation we heard from patients, healthcare professionals and others that it is important that immediate-release fentanyl is available for use in palliative care. The joint clinical working group therefore decided that the three original proposed recommendations should remain but that a defined exemption and clarification should be provided for use as outlined in NICE guidance for palliative care.

Glucosamine and Chondroitin - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for glucosamine and chondroitin.

Herbal Treatments - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for Herbal treatments.

Homeopathy – During the consultation we heard a range of views both agreeing and disagreeing with our proposals on homeopathy. Due to the volume of evidence submitted a further review of the evidence was commissioned from the Specialist Pharmacy Service (SPS) by NHS England. The SPS review found that there was no clear or robust evidence base to support the use of homeopathy in the NHS and therefore, also taking into account responses received from medical and scientific bodies, the joint clinical working group did not feel it necessary to amend the proposed recommendations for homeopathy.

Lidocaine Plasters - During the consultation we heard from patients, healthcare professionals and others that there may be some specialist uses for this item which may be outside the terms of its license. We also received further submissions of evidence and a review of this evidence was commissioned from the Specialist Pharmacy Service (SPS) by NHS England. The joint clinical working group

considered the consultation feedback and the SPS evidence review and decided that the three recommendations should remain, but that a defined exemption and clarification should be provided for the use of lidocaine plasters in Post Herpetic Neuralgia (PHN) only, for which it is licensed in adults and for which there is some evidence of efficacy.

Liothyronine - We received a significant number of responses during the consultation around liothyronine. The main recurring theme – particularly from patients and organisational bodies - is that liothyronine is an effective treatment which is invaluable to patient wellbeing, quality of life and condition management. We also heard that a small proportion of patients treated with levothyroxine continue to suffer with symptoms despite adequate biochemical correction. The joint clinical working group considered the consultation feedback and therefore decided that liothyronine should still be prescribed for a small cohort of patients. The joint clinical working group changed the recommendations so that initiation of prescribing of liothyronine in appropriate patients should be initiated by a consultant endocrinologist in the NHS, and that deprescribing in 'all' patients is not appropriate as there are recognised exceptions.

Lutein and Antioxidants – As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for lutein and antioxidants.

Omega-3 Fatty Acid Compounds - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for omega-3 fatty acid compounds.

Oxycodone and Naloxone combination product - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for oxycodone and naloxone combination product.

Paracetamol and Tramadol combination product - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for paracetamol and tramadol Combination Product.

Perindopril Arginine - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for perindopril arginine.

Rubefacients (excluding topical NSAIDs) - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for rubefacients (excluding topical NSAIDs).

Once daily Tadalafil - As a result of what we heard the joint clinical working group did not feel it necessary to amend the proposed recommendations for once daily tadalafil.

Vaccines administered exclusively for the purposes of travel - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for vaccines administered *exclusively for the purposes of*

travel. However we did hear that confusion persists around travel vaccines and we have amended the wording of our guidance to reduce confusion.

Trimipramine - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for deprescribing trimipramine however the group felt that there would not be cases of exceptionality that would warrant referral to a multidisciplinary team so removed that recommendation.

Whilst not a part of our consultation, the Department of Health recently consulted on the availability of Gluten free foods in primary care. The Department of Health will make recommendations in due course and we have removed references to Gluten free foods from this commissioning guidance.

2 How will this guidance be updated and reviewed?

To ensure that the NHS continues to allocate its resources effectively, the joint clinical working group will review the guidance at least annually (or more frequently if required) to identify potential items to be retained, retired or added to the current guidance. There will be three stages:

Item identification
Organisations represented on the joint clinical working group will, taking into account previous feedback, identify items from the wide range of items that can be prescribed on NHS prescription in primary care in the categories defined in section 1.3.

Item prioritisation
The joint clinical working group will prioritise items based on the following criteria:

- Safety Issue
- Evidence of efficacy
- Degree of variation in prescribing
- Cost to the NHS
- Clinician or patient feedback

In order to seek initial views from interested parties, a draft list of items will be made available online through the NHS England website for a four week period, when comments will be sought. Organisations detailed in Appendix 1 and others where appropriate may be sent an invitation to comment. Feedback will then be collated and published on the NHS England website.

Item selection for inclusion or removal from the guidance
The joint clinical working group will consider the feedback and produce a final list of recommendations for consideration by NHS England and NHS Clinical Commissioners to update the proposed commissioning guidance for items which should not be routinely prescribed in primary care. It is envisaged that we will now consult formally on these recommendations as has been done for the products included in this guidance.

3 Definitions

Annual Spend: Unless otherwise indicated this is the total value from NHS Prescription Services at the NHS Business Services Authority. Prescriptions written by General Medical Practitioners and non-medical prescribers (nurses, pharmacists etc.) in England represent the vast majority of prescriptions included. Prescriptions written by dentists and hospital doctors are also included provided that they were dispensed in the community. Also included are prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England. Prescriptions written in England but dispensed outside England are not included. The figure quoted is the net ingredient cost which refers to the cost of the drug before discounts and does not include any dispensing costs or fees. It does not include any adjustment for income obtained where a prescription charge is paid at the time the prescription is dispensed or where the patient has purchased a prepayment certificate.

BNF: British National Formulary provides healthcare professionals with authoritative and practical information on the selection and clinical use of medicines.

Exceptional Circumstances: In the context of this guidance, “exceptional circumstances” should be interpreted as: Where the prescribing clinician considers no other medicine or intervention is clinically appropriate and available for the individual

Item: An item is anything which can be prescribed on an NHS prescription. More information on what is prescribed on an NHS prescription is available in the Drug Tariff.

New patient: This refers to any patient newly initiated on an item listed in the guidance.

NICE: The National Institute for Health and Care Excellence. They provide the NHS with clinical guidance on how to improve healthcare.

MHRA: Medicines and Healthcare products Regulatory Agency. They regulate medicines, medical devices and blood components for transfusion in the UK.

NHS Clinical Commissioners: NHSCC are the independent membership organisation for CCGs, providing their collective voice, facilitating shared learning and delivering networking opportunities for CCG members.

PHE: Public Health England. They protect and improve the nation's health and wellbeing, and reduce health inequalities.

PrescQIPP CIC (Community Interest Company): PrescQIPP are an NHS funded not-for-profit organisation that supports quality, optimised prescribing for patients. They produce evidence-based resources and tools for primary care commissioners, and provide a platform to share innovation across the NHS.

4 Recommendations

Our final recommendations by product are listed below.

4.1 Co-proxamol

Recommendation	• Advise CCGs that prescribers in primary care should not initiate co-proxamol for any new patient. • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£9,002,824 (NHS Digital)
Background and Rationale	Co-proxamol was a pain-killer which was previously licensed in the UK until being fully withdrawn from the market in 2007 due to safety concerns. All use in the UK is now on an unlicensed basis. Since 1985 advice aimed at the reduction of co-proxamol toxicity and fatal overdose has been provided, but this was not effective and resulted in withdrawal of co-proxamol by the MHRA. Since the withdrawal, further safety concerns have been raised which have resulted in co-proxamol being withdrawn in other countries. Due to the significant safety concerns, the joint clinical working group considered co-proxamol suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs	MHRA Drug Safety Update: November 2007, January 2011 PrescQIPP CIC Drugs to Review for Optimised Prescribing - Co-proxamol Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.2 Dosulepin

Recommendation	• Advise CCGs that prescribers in primary care should not initiate dosulepin for any new patient. • Advise CCGs to support prescribers in deprescribing dosulepin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£2,651,544 (NHS Digital)
Background and Rationale	Dosulepin, formerly known as dothiepin, is a tricyclic antidepressant. NICE CG90: Depression in Adults has a "do not do" recommendation: "*Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose.*" Due to the significant safety concerns advised by NICE, the joint clinical working group considered dosulepin suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs	NICE CG90: Depression in Adults PrescQIPP CIC Drugs to Review for Optimised Prescribing - Dosulepin Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.3 Prolonged-release Doxazosin (also known as Doxazosin Modified Release

Recommendation	• Advise CCGs that prescribers in primary care should not initiate prolonged-release doxazosin for any new patient. • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£7,769,931 (NHS Digital)
Background and Rationale	Doxazosin is an alpha-adrenoceptor blocking drug that can be used to treat hypertension and benign prostatic hyperplasia. There are two oral forms of the medication (immediate release and prolonged-release) and both are taken once daily. Prolonged-release Doxazosin is approximately six times the cost of doxazosin immediate release (NHS Drug Tariff). NICE CG127 Hypertension in adults: diagnosis and management recognises that doxazosin should be used in treatment but does not identify benefits of prolonged-release above immediate release. NICE CG97 Lower urinary tract symptoms in men: management recommends Doxazosin as an option in men with moderate to severe lower urinary tract symptoms. It does not identify benefits of Prolonged-release above immediate release. Due to the significant extra cost of prolonged-release doxazosin and the availability of once daily immediate release doxazosin, the joint clinical working group considered prolonged-release doxazosin suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs	NICE CG127 Hypertension in adults: diagnosis and management NICE CG97 Lower urinary tract symptoms in men PrescQIPP CIC Drugs to Review for Optimised Prescribing - Prolonged Release Doxazosin BNF - Doxazosin

	Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.4 Immediate Release Fentanyl

Recommendation	• Advise CCGs that prescribers in primary care should not initiate immediate release fentanyl for any new patient. • 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. • 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.
Exceptions and further recommendations	**These recommendations do not apply to patients undergoing palliative care treatment** and where the recommendation to use immediate release fentanyl in line with NICE guidance (see below), has been made by a multi-disciplinary team and/or other healthcare professional with a recognised specialism in palliative care.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£10, 952,130 (NHS Digital)
Background and Rationale	Fentanyl is a strong opioid analgesic. It is available as an immediate release substance in various dosage forms; tablets, lozenges, films and nasal spray. Immediate release fentanyl is licensed for the treatment of breakthrough pain in adults with cancer who are already receiving at least 60mg oral morphine daily or equivalent. NICE CG140 Opioids in Palliative Care states *Do not offer fast-acting fentanyl as first-line rescue medication.* This recommendation does not apply to longer sustained release versions of fentanyl which come in patch form. Due to the recommendations from NICE and immediate release fentanyl being only licensed for use in cancer, the joint clinical working group considered immediate release fentanyl was suitable for inclusion in this guidance with specific exceptions for people receiving palliative care reflecting NICE and the terms of the product licence.

Further Resources and Guidance for CCGs	Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain PrescQIPP CIC Drugs to Review for Optimised Prescribing - Immediate Release Fentanyl Faye's story: good practice when prescribing opioids for chronic pain Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.5 Glucosamine and Chondroitin

Recommendation	• Advise CCGs that prescribers in primary care should not initiate Glucosamine and Chondroitin for any new patient. • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£444,535 (NHS Digital)
Background and Rationale	Glucosamine and Chondroitin are nutraceuticals which used to improve pain associated with osteoarthritis. The BNF states the following about glucosamine, *The mechanism of action is not understood and there is limited evidence to show it is effective.* NICE CG177: Osteoarthritis care and management has the following "do not do" recommendation: *Do not offer glucosamine or chondroitin products for the management of osteoarthritis* Due to the recommendation from NICE and due to the lack of evidence as advised by the BNF, the joint clinical working group considered glucosamine and chondroitin suitable for inclusion in this guidance
Further	BNF

Resources and Guidance for CCGs and prescribers	NICE CG177: Osteoarthritis care and management PrescQIPP CIC Drugs to Review for Optimised Prescribing - Glucosamine Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.6 Herbal Treatments

Recommendation	• Advise CCGs that prescribers in primary care should not initiate herbal items for any new patient • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£100,009 (Source: NHS Business Services Authority)
Background and Rationale	Under a Traditional Herbal Registration there is no requirement to prove scientifically that a product works, the registration is based on longstanding use of the product as a traditional medicine. Due to the lack of scientific evidence required to register these products with the MHRA, the joint clinical working group felt that they were suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs and prescribers	GOV.UK Traditional herbal medicines: registration form and guidance GOV.UK Herbal medicines granted a traditional herbal registration (THR) Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.7 Homeopathy

Recommendation	• Advise CCGs that prescribers in primary care should not initiate homeopathic items for any new patient • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£92,412 (NHS Digital)
Background and Rationale	Homeopathy seeks to treat patients with highly diluted substances that are administered orally. During the consultation we received a range of submissions pertaining to homeopathy and it was deemed necessary to have a further, up to date review of the evidence which was conducted by the Specialist Pharmacy Service. The review found that there was no clear or robust evidence to support the use of homeopathy on the NHS.
Further Resources and Guidance for CCGs and prescribers	Specialist Pharmacy Service homeopathy evidence review: https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/ GOV.UK Register a homeopathic medicine or remedy Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.8 Lidocaine Plasters

Recommendation	• Advise CCGs that prescribers in primary care should not initiate lidocaine plasters for any new patient (apart from exceptions below) • 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. • Advise CCGs that if, in exceptional circumstances, there is a clinical need for lidocaine plasters to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.
Exceptions and further recommendations	These recommendations do not apply to patients who have been treated in line with NICE CG173 *Neuropathic pain in adults: pharmacological management in non-specialist settings* but are still experiencing neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia).
Category	Item of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns
Annual Spend	£19,295,030 (NHS Digital)
Background and Rationale	Lidocaine plasters can be applied for pain relief and are licensed for symptomatic relief of neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia, PHN) in adults. NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings does not recommend lidocaine plasters for treating neuropathic pain. The joint clinical working group also considered a PrescQIPP CIC review, and during the consultation more evidence was provided and an up to date evidence summary was deemed necessary and prepared by the Specialist Pharmacy Service to inform the joint clinical working group's recommendations. Based on this review and non-inclusion, the lidocaine plasters are included with defined exceptions.
Further Resources and Guidance for CCGs and prescribers	NICE Clinical Knowledge Summaries - Post-herpetic neuralgia Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets Specialist Pharmacy Service lidocaine plasters evidence review: https://www.england.nhs.uk/medicines/items-which-should-not-

	be-routinely-prescribed/

4.9 Liothyronine (including Armour Thyroid and liothyronine combination products)

Recommendation	• Advise CCGs that prescribers in primary care should not initiate liothyronine for any new patient • Advise CCGs that individuals currently prescribed liothyronine should be reviewed by a consultant NHS endocrinologist with consideration given to switching to levothyroxine where clinically appropriate. • Advise CCGs that a local decision, involving the Area Prescribing Committee (or equivalent) informed by National guidance (e.g. from NICE or the Regional Medicines Optimisation Committee), should be made regarding arrangements for on-going prescribing of liothyronine. This should be for individuals who, in exceptional circumstances, have an on-going need for liothyronine as confirmed by a consultant NHS endocrinologist.
Exceptions and further recommendations	The British Thyroid Association (BTA) advise that a small proportion of patients treated with levothyroxine continue to suffer with symptoms despite adequate biochemical correction. In these circumstances, where levothyroxine has failed and in line with BTA guidance, endocrinologists providing NHS services may recommend liothyronine for individual patients after a carefully audited trial of at least 3 months duration of liothyronine. Liothyronine is used for patients with thyroid cancer, in preparation for radioiodine ablation, iodine scanning, or stimulated thyroglobulin test. In these situations it is appropriate for patients to obtain their prescriptions from the centre undertaking the treatment and not be routinely obtained from primary care prescribers.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£34,802,312 (NHS Digital) In addition £1,000,049 is spent on Liothyronine + Levothyroxine combination products e.g. armour thyroid
Background and Rationale	Liothyronine (sometimes known as T3) is used to treat hypothyroidism. It has a similar action to levothyroxine but is more rapidly metabolised and has a more rapid effect. It is

	sometimes used in combination with levothyroxine in products. The price (NHS Drug Tariff) of liothyronine has risen significantly and there is limited evidence for efficacy above Levothyroxine. The British Thyroid Association, in their 2015 position statement, state "*There is no convincing evidence to support routine use of thyroid extracts, L-T3 monotherapy, compounded thyroid hormones, iodine containing preparations, dietary supplementation and over the counter preparations in the management of hypothyroidism".* Due to the significant costs associated with liothyronine and the limited evidence to support its routine prescribing in preference to levothyroxine, the joint clinical working group considered liothyronine suitable for inclusion in this guidance. However during the consultation we heard and received evidence about a cohort of patients who require liothyronine and the clinical working group felt it necessary to include some exceptions based on guidance from the British Thyroid Association.
Further Resources and Guidance for CCGs and prescribers	British Thyroid Association Guidelines UKMI Medicines Q&A - What is the rationale for using a combination of levothyroxine and liothyronine (such as Armour® Thyroid) to treat hypothyroidism? Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.10 Lutein and Antioxidants

Recommendation	• Advise CCGs that prescribers in primary care should not initiate lutein and antioxidants for any new patient • Advise CCGs to support prescribers in deprescribing lutein and antioxidants in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£1,500,000 (NHS Digital)
Background and Rationale	Lutein and antioxidants (e.g. vitamin A, C E and zinc) are supplements which are sometimes recommended for Age Related Macular Degeneration. A variety of supplements are available to purchase in health food stores and other outlets where they are promoted to assist with "eye health". Two Cochrane Reviews have been conducted on this topic **Antioxidant vitamin and mineral supplements for preventing age-related macular degeneration** http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000253.pub3/full The authors conclude *"There is accumulating evidence that taking vitamin E or beta-carotene supplements will not prevent or delay the onset of AMD. There is no evidence with respect to other antioxidant supplements, such as vitamin C, lutein and zeaxanthin, or any of the commonly marketed multivitamin combinations".* **Antioxidant vitamin and mineral supplements for slowing the progression of age-related macular degeneration** http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000254.pub3/full The authors conclude *"People with AMD may experience delay in progression of the disease with antioxidant vitamin and mineral supplementation. This finding is drawn from one large trial conducted in a relatively well-nourished American population. The generalisability of these findings to other populations is not known."* PrescQIPP CIC has issued a bulletin which did not find evidence to support prescribing of lutein and antioxidants routinely on the NHS. NICE have published draft consultation guidance on Age-Related Macular Degeneration and proposed that the effectiveness and cost-effectiveness of the use of lutein and

	antioxidants is currently a research recommendation.
Further Resources and Guidance for CCGs and prescribers	PrescQIPP CIC Drugs to Review for Optimised Prescribing - Lutein and Antioxidants NICE - Macular Degeneration Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.11 Omega-3 Fatty Acid Compounds

Recommendation	• Advise CCGs that prescribers in primary care should not initiate omega-3 Fatty Acids for any new patient. • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Item of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns
Annual Spend	£6,317,927 per annum (NHS Digital)
Background and Rationale	Omega-3 fatty acid compounds are essential fatty acids which can be obtained from the diet. They are licensed for adjunct to diet and statin in type IIb or III hypertriglyceridemia; adjunct to diet in type IV hypertriglyceridemia; adjunct in secondary prevention in those who have had a myocardial infarction in the preceding 3 months. NICE have reviewed the evidence and advised they are not suitable for prescribing by making “Do not do” recommendations Do not offer or advise people to use omega-3 fatty acid capsules or omega-3 fatty acid supplemented foods to prevent another myocardial infarction. If people choose to take omega-3 fatty acid capsules or eat omega-3 fatty acid supplemented foods, be aware that there is no evidence of harm. Do not offer omega-3 fatty acid compounds for the prevention of cardiovascular disease to any of the following: people who are being treated for primary prevention, people who are being treated for secondary prevention, people with chronic kidney disease, people with type 1 diabetes, people with type 2 diabetes.

	Do not offer the combination of a bile acid sequestrant (anion exchange resin), fibrate, nicotinic acid or omega-3 fatty acid compound with a statin for the primary or secondary prevention of CVD. Do not offer omega-3 fatty acids to adults with non-alcoholic fatty liver disease because there is not enough evidence to recommend their use. Initiation of omega-3-acid ethyl esters supplements is not routinely recommended for patients who have had a myocardial infarction (MI) more than 3 months earlier. Do not use omega-3 fatty acids to manage sleep problems in children and young people with autism. People with familial hypercholesterolemia (FH) should not routinely be recommended to take omega-3 fatty acid supplements. Do not offer omega-3 or omega-6 fatty acid compounds to treat multiple sclerosis (MS). Explain that there is no evidence that they affect relapse frequency or progression of MS. The joint clinical working group agreed with NICE recommendations and considered omega-3 fatty acid compounds suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs and prescribers	NICE - Omega-3 PrescQIPP CIC Drugs to Review for Optimised Prescribing - Omega 3 Fatty Acids Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.12 Oxycodone and Naloxone Combination Product

Recommendation	• Advise CCGs that prescribers in primary care should not initiate oxycodone and naloxone combination product for any new patient. • 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. • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£5,062,928 (NHS Digital)
Background and Rationale	Oxycodone and naloxone combination product is used to treat severe pain and can also be used second line in restless legs syndrome. The opioid antagonist naloxone is added to counteract opioid-induced constipation by blocking the action of oxycodone at opioid receptors locally in the gut. PrescQIPP CIC have issued a bulletin and did not identify a benefit of oxycodone and naloxone in a single product over other analgesia (with laxatives if necessary). Due to the significant cost of the oxycodone and naloxone combination product and the unclear role of the combination product in therapy compared with individual products, the joint clinical working group considered oxycodone and naloxone suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs and prescribers	Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain Faye's story: good practice when prescribing opioids for chronic pain PrescQIPP CIC Drugs to Review for Optimised Prescribing - Oxycodocne and Naloxone Combination Product

	Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.13 Paracetamol and Tramadol Combination Product

Recommendation	• Advise CCGs that prescribers in primary care should not initiate paracetamol and tramadol combination product for any new patient. • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£1,980,000 (NHS Digital)
Background and Rationale	Paracetamol and tramadol combination products are more expensive than the products with the individual components (Drug Tariff). PrescQIPP CIC also issued a bulletin which did not identify any significant advantages over individual products, however it does recognise that some people may prefer to take one product instead of two. There are also different strengths of tramadol (37.5mg) and paracetamol (325mg) in the combination product compared to commonly available individual preparations of tramadol (50mg) and paracetamol (500mg), although the PrescQIPP CIC review found no evidence that combination product is more effective or safer than the individual preparations. Due to the significant extra cost of a combination product, the joint clinical working group considered paracetamol and tramadol combination products suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs and prescribers	PrescQIPP CIC Drugs to Review for Optimised Prescribing - Paracetamol and Tramadol Combination Product Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.14 Perindopril Arginine

Recommendation	• Advise CCGs that prescribers in primary care should not initiate perindopril arginine for any new patient. • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£529,403 (NHS Digital)
Background and Rationale	Perindopril is an ACE inhibitor used in heart failure, hypertension, diabetic nephropathy and prophylaxis of cardiovascular events. The perindopril arginine salt version was developed as it is more stable in extremes of climate than the perindopril erbumine salt, which results in a longer shelf-life. perindopril arginine is significantly more expensive than perindopril erbumine and a PrescQIPP CIC review of the topic found there was no clinical advantage of the arginine salt. NICE CG127: Hypertension in adults: diagnosis and management recommends that prescribing costs are minimised. Due to the significant extra costs with the arginine salt and the availability of the erbumine salt, the joint clinical working group considered perindopril arginine suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs and prescribers	NICE CG127: Hypertension in adults: diagnosis and management PrescQIPP CIC Drugs to Review for Optimised Prescribing - Perindopril Arginine Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.15 Rubefacients (excluding topical NSAIDs[5])

Recommendation	• Advise CCGs that prescribers in primary care should not initiate rubefacients (excluding topical NSAIDs) for any new patient. • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£4,301,527 (source: NHS BSA)
Background and Rationale	Rubefacients are topical preparations that cause irritation and reddening of the skin due to increased blood flow. They are believed to relieve pain in various musculoskeletal conditions and are available on prescription and in over-the-counter remedies. They may contain nicotinate compounds, salicylate compounds, essential oils and camphor. The BNF states *"The evidence available does not support the use of topical rubefacients in acute or chronic musculoskeletal pain."* NICE have issued the following "Do not do" recommendation: Do not offer rubefacients for treating osteoarthritis. Due to limited evidence and NICE recommendations the joint clinical working group considered rubefacients (excluding topical NSAIDS) suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs and prescribers	PrescQIPP CIC Drugs to Review for Optimised Prescribing - Rubefacients NICE CG177 Osteoarthritis: care and management BNF: Soft-tissue disorders Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

[5] This does not relate to topical non-steroidal anti-inflammatory drug (NSAID) items such as Ibuprofen and Diclofenac.

4.16 Once Daily Tadalafil

Recommendation	• Advise CCGs that prescribers in primary care should not initiate once daily tadalafil for any new patient • 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.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products which are clinically effective but where more cost-effective products are available this includes products that have been subject to excessive price inflation.
Annual Spend	£11,474,221 (NHS Digital)
Background and Rationale	Tadalafil is a phosphodiesterase-5-inhibitor and is available in strengths of 2.5mg, 5mg, 10mg and 20mg used to treat erectile dysfunction. In addition 2.5mg and 5mg can be used to treat benign prostatic hyperplasia. Only 2.5mg and 5mg should be used once daily. 10mg and 20mg[6] are used in a "when required fashion". Tadalafil can be prescribed for erectile dysfunction in circumstances as set out in part XVIIIB of the Drug Tariff. Benign Prostatic Hyperplasia: NICE terminated their technology appraisal (TA273) due to receiving no evidence from the manufacturer. In NICE CG97: Lower Urinary Tract Symptoms in Men NICE state that there is not enough evidence to recommend phosphodiesterase inhibitors in routine clinical practice. Erectile Dysfunction: PrescQIPP CIC have reviewed the evidence for Tadalfil and although tadalafil is effective in treating erectile dysfunction, there is not enough evidence to routinely recommend once daily preparations in preference to "when required" preparations particularly as when required preparations are now available as a generic. Due to recommendations from NICE and that alternative tadalafil preparations are available, the joint clinical working group felt once daily tadalafil was suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs and	NICE CG97: Lower Urinary Tract Symptoms in Men NICE Clinical knowledge Summaries - Erectile Dysfunction

[6] *There is also a 20mg once daily preparation, branded *Adcirca*, which is used to treat pulmonary hypertension. This recommendation does not apply to this product, however it should only be prescribed by specialist centres and not routinely prescribed in primary care.

prescribers	PrescQIPP CIC Drugs to Review for Optimised Prescribing - Once Daily Tadalafil Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.17 Travel Vaccines (vaccines administered exclusively for the purposes of travel)

Recommendation	• Advise CCGs that prescribers in primary care should not initiate the stated vaccines exclusively for the purposes of travel for any new patient. **N.B This is a restatement of existing regulations and no changes have been made as a result of this guidance.**
Exceptions and further recommendations	The vaccines in this proposal are listed below and they may continue to be administered for purposes other than travel, if clinically appropriate. NHS England and NHS Clinical Commissioners recognise that the availability of vaccinations on the NHS for the purposes of travel can be confusing for prescribers and the public. The working group has recommended that Public Health England and Department of Health, working collaboratively with NHS England and NHS Clinical Commissioners, conduct a review of travel vaccination and publish the findings in Spring 2018.
Category	Items which are clinically effective but due to the nature of the product, are deemed a low priority for NHS funding.
Annual Spend	£4,540,351 (NHS Digital) Only some of this total will be administered for the purposes of travel.
Background and Rationale	To note the following vaccines may still be administered on the NHS exclusively for the purposes of travel, if clinically appropriate, pending any future review: • Cholera • Diphtheria/Tetanus/Polio • Hepatitis A • Typhoid This guidance covers the following vaccinations which should not be prescribed on the NHS exclusively for the purposes of travel: • Hepatitis B • Japanese Encephalitis • Meningitis ACWY

	• Yellow Fever • Tick-borne encephalitis • Rabies • BCG These vaccines should continue to be recommended for travel but the individual traveller will need to bear the cost of the vaccination. For all other indications, as outlined in Immunisation Against Infectious Disease – the green book – the vaccine remains free on the NHS.
Further Resources and Guidance for CCGs and prescribers	The Green Book Travel Health Pro (NaTHNaC) PrescQIPP CIC Drugs to Review for Optimised Prescribing - Travel Guidance Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.18 Trimipramine

Recommendation	• Advise CCGs that prescribers in primary care should not initiate trimipramine for any new patient. • Advise CCGs to support prescribers in deprescribing trimpramine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£19,835,783 (NHS Digital)
Background and Rationale	Trimipramine is a tricyclic antidepressant (TCA) however the price of trimipramine is significantly more expensive than other antidepressants. NICE CG90: Depression in Adults recommends selective serotonin reuptake inhibitor (SSRI) antidepressants first line if medicines are indicated as they have a more favourable risk:benefit ratio compared to TCA. However if a TCA is required there are more cost-effective TCAs than trimipramine available.

	Due to the significant cost associated with trimipramine and the availability of alternative treatments, the joint clinical working group considered trimipramine suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs and prescribers	NICE CG90: Depression in Adults NICE Clinical Knowledge Summaries – Depression Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

Appendix 1

Membership of the Joint Clinical Working group

Graham Jackson (Co-chair)	NHSCC Co-chair and Clinical Chair Aylesbury CCG	NHS Clinical Commissioners & Aylesbury Vale CCG
Bruce Warner (Co-chair)	Deputy Chief Pharmaceutical Officer	NHS England
Arvind Madan	Director of Primary Care and Deputy Medical Director	NHS England
Julie Wood	Chief Executive	NHS Clinical Commissioners
David Webb	Regional Pharmacist	NHS England
David Geddes	Director of Primary Care Commissioning	NHS England
Paul Chrisp	Programme Director, Medicines and Technologies Programme	NICE
Claire Potter	Medicines and Pharmacy	Department of Health
Carol Roberts	Chief Executive	PrescQIPP CIC
Margaret Dockey	Information Services Manager	NHS Business Services Authority
Manir Hussain	Local professional Network Chair & Assoc Director Medicines Optimisation	NHS England & North Staffs/Stoke on Trent CCGs
Duncan Jenkins	Pharmaceutical Public Health	Dudley Public Health/CCG
Kate Arnold	Head of Medicines and Primary Care Development	Solihull CCG
Paul Gouldstone	Head of Medicines Management	Enfield CCG
Steve Pike	Clinical Lead Medicines Management	Coastal West Sussex CCG
David Paynton	National Clinical Lead for Commissioning	Royal College of GPs
Robbie Turner	Director for England	Royal Pharmaceutical Society
Lauren Hughes	Director, Clinical Policy and Operations	NHS England

Stakeholder Organisations

Association of the British Pharmaceutical Industry (ABPI)	NHS Clinical Commissioners
Aylesbury Vale CCG	NHS England
British Generic Manufacturers Association	NHS Improvement
British Medical Association (General Practitioners Committee)	NICE
Care Quality Commission	Patients Association
Department of Health	Pharmaceutical Services Negotiating Committee (PSNC)
Enfield CCG	PrescQIPP
General Medical Council	Public Health England
Healthwatch England	Royal Pharmaceutical Society
National Voices	