PrescQIPP
Community Interest Company

Items which should not routinely be prescribed in primary care: Phase 3

This is the overarching document to a number of bulletins providing further information on additional items that should be given a low priority for prescribing on the NHS, are poor value for money, suitable for self-care or for which there are safer, more suitable alternatives. This guidance will support Clinical Commissioning Groups (CCGs) in taking action on items that should not routinely be prescribed in primary care or on the NHS. The guidance supports the implementation of the NHS England guidance, which is available here:
https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/

Recommendations

- Review all patients prescribed an item in the 'items which should not routinely be prescribed in primary care' list.
- Determine whether:
  - To stop prescribing the item and provide the patient with advice on self-care or alternatives.
  - To change the item to a more cost-effective/safer choice and provide the patient with information on why the item has been changed.
  - There are exceptional circumstances in which it may be appropriate to continue treatment. Ensure that the patient is assessed and managed through a multidisciplinary team as appropriate.
- For items available to purchase over-the-counter (OTC), recommend self care and purchase of the item OTC with support and advice from the community pharmacist wherever appropriate.

Supporting information

Supporting resources are available for each of the eight treatments set out in this document via www.prescqipp.info

These resources will support medicines optimisation by ensuring:[1]

- Treatments of limited clinical value are not used and items no longer required are stopped.
- Optimal patient outcomes are obtained from choosing an item using the best available evidence.
- Medicines and appliances wastage is reduced.
- The NHS achieves greater value from money invested in prescribed treatments.
- Patients are more engaged, understand more about their treatments and are able to make choices, including choices about prevention and healthy living.
- It becomes routine practice to signpost patients to further help with their prescribed treatments and to local patient support groups.
- Incidents of avoidable harm from medicines and appliances are reduced.

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Table 1: Items which should not routinely be prescribed in primary care list and total annual spend in England (ePACT April 2019 data)

No	Item	Annual spend in England (ePACT April 2019)
1	Aliskiren	£719,000
2	Amiodarone	£1.2 million
3	Bath and shower preparations for dry and pruritic skin conditions	£5.5 million
4	Dronedarone	£1.4 million
5	Minocycline for acne	£460,000
6	Needles for pre-filled and reusable insulin pens	£28 million
7	Silk garments	£862,000
Total NHS spend		**£38.1 million**

Rationale for inclusion in the list

In certain circumstances, prescribing items considered to be less suitable for routine prescribing in primary care may be appropriate. However, the spend in the areas listed in table 1 shows there is a significant opportunity to promote self care and reduce prescribing of items of limited clinical value, or switch to an alternative product which offers better value for money or a better safety profile.

Table 2 explains:

- Why the item is included in the guidance.
- Where use might be appropriate.
- Suggested alternatives.
- Links to associated resources to support change (if available).
- Indicative savings if the change is made (based on average costs across a range of strengths and products).

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Table 2: Supporting information for items included in the list

Item	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual savings
Aliskiren (Rasilez®)	Aliskiren is not recommended for primary hypertension, due to insufficient clinical and cost-effectiveness data.[2,3] Insufficient evidence of its effectiveness to determine its suitability for use in resistant hypertension.[2] In addition, adverse drug reactions data confirm a risk of adverse outcomes (hypotension, syncope, stroke, hyperkalaemia and change in renal function including acute renal failure) when aliskiren is combined with ACE inhibitors or angiotensin II receptor blockers, especially in patients with diabetes and those with impaired renal function.[4]	None foreseen.	Follow the advice in NICE CG127 on the diagnosis and management of hypertension in adults.[2]	Assuming an 80% reduction in prescribing: £575,000 Some of this saving will be offset if another treatment is needed.

Item	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual savings
Amiodarone	Amiodarone is no longer recommended for long-term rate control in atrial fibrillation (AF).[5] There is a risk of potentially fatal long-term side-effects, and alternative treatments are available.[6]	Amiodarone may still be considered for:[5] • Rhythm control in people with left ventricular impairment or heart failure • Pre (four weeks) and post (up to 12 months) electrical cardioversion • Pharmacological cardioversion in new onset AF with evidence of structural heart disease • Pharmacological cardioversion in new onset AF with no evidence of structural or ischaemic heart disease • People undergoing cardiothoracic surgery to reduce risk of post-operative AF Must be initiated by a specialist and only continued under a shared care arrangement for patients where other treatments cannot be used, have failed or is in line with NICE Guidance CG180.[7]	A rate-control treatment (beta-blocker other than sotalol or rate limiting calcium-channel blocker) is recommended for most people with AF.[5] Digoxin or dronedarone may be considered in specific circumstances.[5] Flecainide may also be considered in people with no evidence of structural or ischaemic heart disease.[5]	Assuming a 50% reduction in prescribing: £600,000 annually.

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Item	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual savings
Bath and shower preparations for dry and pruritic skin conditions	There is no evidence of clinical benefit for including pour in emollient bath additives in the standard management of eczema.[8,9] Evidence to inform practice on the use of proprietary non-soap cleansers used as a soap substitute is limited although some guidelines do recommend their use.[10, 11] Preparations containing an antibacterial should be avoided unless infection is present or is a frequent complication.[6]	Soap avoidance and 'leave-on' emollient moisturisers should still be used for treating eczema and these emollients can still be used as soap substitutes.[9] Patients should be counselled on the use of any emollients as soap substitutes and the risk of using bath and shower emollients should be fully explained.[7] Proprietary wash products are expensive and should not be used due to the lack of evidence to support their use.	Advise to purchase proprietary products over-the-counter if still required. Some useful patient resources, including a plain language video of the results of the BATHE study, can be found along with the full article on the BMJ website: https://www.bmj.com/content/361/bmj.k1332	Assuming an 80% reduction in prescribing: £4.4 million annually.

Item	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual savings
Dronedarone	NICE puts greater emphasis on rate rather than rhythm control and has clarified the place of dronedarone in the AF treatment pathway.[5] Dronedarone is only recommended as an option for the maintenance of sinus rhythm after successful cardioversion in people with paroxysmal or persistent AF:[5] • As a second-line treatment option (because AF is not controlled by first line therapy, usually including beta-blockers) and after alternative options have been considered. **and** • For those who have at least one of the following cardiovascular risk factors: » Hypertension requiring drugs of at least two different classes » Diabetes mellitus » Previous transient ischaemic attack, stroke or systemic embolism » Left atrial diameter of 50 mm or greater or » Age 70 years or older **and** » Who do not have left ventricular systolic dysfunction and » Who do not have a history of, or current, heart failure.	In line with the specific indications set out by NICE.[5] Dronedarone must only be initiated by a specialist and only continued under a shared care arrangement.[6]	A rate-control treatment (beta-blocker except sotalol or a rate limiting calcium-channel blocker) is recommended for most people with AF.[5] Digoxin may be considered in specific circumstances.[5]	Assuming an 80% reduction in prescribing: £1.1 million annually.

Item	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual savings
Minocycline for acne	Minocycline has various safety risks associated with its use, such as drug induced lupus, skin pigmentation and hepatitis.[12] There is also no clear evidence that it is more effective or better tolerated than other tetracyclines and it has a high acquisition cost.[12]	None foreseen.	Alternative once-daily preparations include doxycycline and lymecycline.	Assuming an 80% reduction in prescribing: £368,000 annually.
Needles for pre-filled and reusable insulin pens	There are many different types of insulin pen needles available at a varying cost.[13] The Forum for Injection Technique (FIT) UK considers the 4mm needle to be the safest pen needle for adults and children regardless of age, gender and Body Mass Index (BMI).[14] Using needles of a shorter length helps to prevent intramuscular injection of insulin. (IM injection of insulin should be avoided as it can result in unpredictable blood glucose levels).[14] Therefore needle choice should be the most cost effective 4mm needle.	None foreseen.	Needle choice should be the most cost-effective 4mm needle. Cost should not exceed >£5 per 100 needles. *N.B. Patients currently using longer pen needle lengths (8mm, 12mm) should first receive advice from a healthcare professional on the correct injection technique for their new needles.* Refer to PrescQIPP bulletin on hypodermic insulin devices for patients with type 2 diabetes.[15]	Assuming a 50% reduction in spend: £14 million annually.

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Item	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual savings
Silk garments	The evidence relating to the use of silk garments for eczema and atopic dermatitis is weak and of low quality. [16] They are also costly.[13] A trial of use in 300 children found no difference between the two groups in eczema severity assessed by nurses.[17] The CLOTHES trial also looked at whether wearing the silk clothing more often affected the severity of the eczema, but did not find any difference. There was no difference between the two groups in number of skin infections, or quality of life. Wearing the silk clothing did not reduce the number of doctor visits for eczema or use of eczema medications.[17]	None foreseen.	Advise to purchase these items if still required. Useful patient video explaining the trial results showing no difference between the two groups: https://www.nottingham.ac.uk/research/groups/cebd/projects/clothes/index.aspx	Assuming an 80% reduction in prescribing: £690,000 annually.

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Additional PrescQIPP resources

Patient information leaflets (Word and PDF versions)

Available here: https://www.prescqipp.info/our-resources/bulletins/bulletin-243-nhs-low-priority-prescribing-phase-3/

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