PrescQIPP Community Interest Company

The PrescQIPP PROP-List (Products to Review for Optimised Prescribing)

The PrescQIPP DROP-List (meaning Drugs to Review for Optimised Prescribing) was first published in 2012. Since then it has been developed and updated, and in 2017 a medical devices DROP-List was published. This latest version now incorporates both medicines and medical devices in a single publication, to be known as the PROP-List (Products to Review for Optimised Prescribing).

The PROP-List is not guidance, it is provided as an aid to formulary decisions for policy-makers. It makes commissioning recommendations for CCG/HB/ICSs to consider for local adoption. Where appropriate, it considers the need for local pathways and waste minimisation strategies, where treatments are offered. Medicines and medical devices may be included in the PROP-List if they fall into any of the following categories:

- Products considered to be low priority, poor value for money or for which there are safer alternatives.
- Products included in a NICE 'do not do' recommendation.
- Products that can potentially be provided as self care, with advice and support from community pharmacists or other health care professionals.
- Products for which there are specific medicines optimisation issues to be addressed to ensure appropriate use and/or to minimise waste.

Another significant change in this update is the removal of items that are now included in guidance on prescribing in primary care from NHS England (see 'National guidance').[1,2] Some of the items removed are the subject of published DROP-List support bulletins; these publications are still available at https://www.prescqipp.info/our-resources/webkits/low-priority-prescribing/. Where appropriate they will be updated in due course.

Recommendations

- Review all people prescribed a medicine or medical device in the PROP-List.
- Follow guidance from NHS England on items which should not be routinely prescribed in primary care, and conditions for which medicines or treatments that are available over the counter (OTC) should not routinely be prescribed in primary care.[1,2]
- Determine whether to:
  - » Continue treatment if the person fulfils circumstances in which use might be appropriate and continues to achieve the expected outcome.
  - » Change the treatment to a more appropriate or more cost-effective choice.
  - » Stop prescribing the medicine or medical device.
- Recommend self care and purchase of OTC medicines or medical devices with support and advice from the community pharmacist or other healthcare professional wherever appropriate.

Recommendations

- For medical devices specifically:
  - Products included in Part IX-Appliances of the Drug Tariff[3] should be subject to local formulary restrictions in the same way that medicines are.
  - Products not listed in Part IX-Appliances of the Drug Tariff should not be prescribed on FP10 even if they are marked with a CE mark.
  - As with medicines, medical devices not included in local formularies should not be routinely prescribed on FP10 prescription, and advice should be sought from the CCG/HB/ICS medicines management team when considering prescribing.
  - Local patient pathways should be available to ensure that medical devices are prescribed appropriately. Pathways should ensure that initial prescribing is accompanied by appropriate instruction and counselling.
  - The route of procurement of medical devices should be agreed in contract negotiations and be clear to practitioners delivering care.
    - Where a medical device is recommended or initiated by a specialist, the specialist should generally prescribe or provide the device, unless alternative arrangements have been agreed locally.
    - It is reasonable for GPs to prescribe consumables and replacement devices only.
  - Many medical devices are reusable and do not need to be reordered on a monthly basis. Such devices should not be added to repeat prescribing systems.

Background

The Medicines and Healthcare products Regulatory Agency (MHRA) provides information on and determines whether a product falls within the definition of a medicinal product (medicine) or a medical device.[4] A medicinal product will have a marketing authorisation (formerly a product licence) from the MHRA.

A medicinal product is:[4]

- Any substance or combination of substances presented as having properties of preventing or treating disease in human beings,
- Any substance or combination of substances that may be used by or administered to human beings with a view to restoring, correcting or modifying a physiological function by exerting a pharmacological, immunological or metabolic action, or making a medical diagnosis.

A medical device is defined as:[4]

- Any instrument, apparatus, appliance, material or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for human beings for the purpose of:
  - Diagnosis, prevention, monitoring, treatment or alleviation of disease or compensation for an injury or handicap,
  - Investigation, replacement or modification of the anatomy or of a physiological process,
  - Control of conception,
  - And which does not achieve its principal intended action in or on the human body by pharmacological, immunological or metabolic means.[4]

Manufacturers need to demonstrate that their medical device meets the regulatory requirements by carrying out a conformity assessment. Under European Union regulations, devices that pass the conformity assessment can be CE marked to show that the medical device has met the requirements. From January 2021 (when the Brexit transition period ended) there will be a number of changes to how medical devices are placed on the market in Great Britain (England, Wales and Scotland). This will include the introduction of a new UK product marking called a UKCA (UK Conformity Assessed) that will be used for certain goods, including medical devices. The CE marking will continue to be recognised in Great Britain until 30 June 2023. For Northern Ireland, different rules will apply to those in Great Britain after the end of the transition period.[5]

Whether or not a medical device is prescribable on FP10 prescription is determined by whether or not it is included in Part IX – Appliances in the Drug Tariff. If a product is listed then it can be prescribed on FP10 prescription. If a device is not listed in Part IX in the Drug Tariff then it cannot be prescribed on an FP10.[3] As is the case for medicinal products, just because a medical device can be prescribed on an FP10, this does not necessarily mean that it is appropriate to do so. NHS organisations may recommend that specific products are not prescribed, for example where they are not considered to be cost-effective choices and/or where there is limited evidence of clinical effectiveness.

If a product is not classified as a medicinal product or a medical device (with the relevant conformity marking), then it could be a food, toiletry or cosmetic and may also be classed as a borderline substance and included in Part XV of the Drug Tariff as an Advisory Committee on Borderline Substances (ACBS) product.

Medicines optimisation

Medicines optimisation is key to achieving the best outcomes for patients. The Royal Pharmaceutical Society Good Practice Guide on Medicines Optimisation suggests a number of principles, along with the outcomes they are intended to influence, that are key in helping support people to get the most out of their medicines.[6] These are also important considerations and aims when reviewing drugs or devices in the PROP-List and include the following:

- Treatments of limited clinical value are not used and medicines or medical devices no longer required are stopped.
- Optimal patient outcomes are obtained from choosing medicines or medical devices using best evidence (for example, following NICE guidance, local formularies etc.) and these outcomes are measured.
- Wastage is reduced.
- The NHS achieves greater value for money invested in medicines or medical devices.
- Patients are more engaged, understand more about their medicines or medical devices 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 medicines or medical devices and to local patient support groups.
- Incidents of avoidable harm from medicines or medical devices are reduced.

National guidance

In November 2017, NHS England published guidance for CCGs on items which should not be routinely prescribed in primary care. This guidance was updated in 2019, and further products/categories were added. Table 1 below lists all of the items included in the guidance. Note that NHS England have defined specific exceptions in relation to some of the items below. See full NHS England Guidance for details.[2]

Table 1. Items which should not routinely be prescribed in primary care

Aliskiren	Immediate release fentanyl	Prolonged-release doxazosin (also known as doxazosin modified release)
Amiodarone	Lidocaine plasters	Paracetamol and tramadol combination product
Bath and shower preparations for dry and pruritic skin conditions	Liothyronine	Perindopril arginine
Co-proxamol	Lutein and antioxidants	Rubefacients (excluding topical NSAIDs and capsaicin)
Dosulepin	Minocycline for acne	Silk garments
Dronedarone	Needles for pre-filled and reusable insulin pens	Once daily tadalafil
Glucosamine and chondroitin	Omega-3 fatty acid compounds	Travel vaccines
Herbal treatments	Oxycodone and naloxone combination product	Trimipramine
Homeopathy		

In March 2018, NHS England published guidance about reducing the prescribing of medicines or treatments that are available to buy over the counter (OTC) without the need to see a doctor.[1] It advises that medicines available to buy OTC should not be prescribed for the conditions listed in table 2.

Table 2. Conditions for which OTC items should not routinely be prescribed in primary care

Acute sore throat	Earwax	Minor burns and scalds
Coughs, colds and nasal congestion	Excessive sweating	Minor conditions associated with pain, discomfort and/or fever. (e.g. aches and sprains, headache, period pain, back pain)
Infant colic	Head lice	Mouth ulcers
Infrequent cold sores of the lip	Indigestion and heartburn	Nappy rash
Cradle cap	Infrequent constipation	Oral thrush
Mild cystitis	Infrequent migraine	Prevention of tooth decay
Conjunctivitis	Insect bites and stings	Ringworm/athletes foot
Haemorrhoids	Mild acne	Teething/mild toothache
Mild irritant dermatitis	Mild dry skin	Threadworms
Dandruff	Sunburn	Travel sickness
Diarrhoea (adults)	Sun protection	Warts and verrucae
Dry eyes/sore tired eyes	Mild to moderate hay fever	

The guidance also advises against the routine prescribing of probiotics and vitamins and minerals sold as food supplements, because most people can and should get these from eating a healthy, varied and balanced diet.[1]

Some general and product specific exceptions are stipulated by NHS England, where medicines for a condition on this list may still be prescribed. General exceptions include:

- Treatment for a long-term condition, e.g. regular pain relief for chronic arthritis, treatments for inflammatory bowel disease or diagnosed vitamin deficiencies.
- Treatment of more complex forms of minor illnesses, e.g. migraines that are very severe where OTC medicines do not work.
- Treatment of complex patients, e.g. immunosuppressed patients.
- Patients on prescription only treatments for their condition.
- Patients prescribed OTC medicines to treat a side-effect of a prescription medicine or symptom of a more complex illness.
- The medicine has a licence which doesn't allow the product to be sold OTC to certain groups of patients. This may vary by medicine, but could include babies, children or women who are pregnant or breast-feeding.
- Treatment of patients with a condition defined as suitable for self care who have tried an OTC product, but found that it did not work.
- The prescriber believes there is a special reason they should prescribe the medicine, for example to treat a condition which they believe is not minor or self-limiting.
- The prescriber thinks that a patient cannot treat themselves, for example because of mental health problems or severe social vulnerability.[1]

For product specific exceptions and further information, see the guidance from NHS England.[1]

Many of the items in table 1 and a number of treatments for conditions listed in Table 2 featured in the previous version of the PrescQIPP DROP-List. They have been removed from this version and added to the low priority prescribing support resources now that national guidance from NHS England is available https://www.prescqipp.info/our-resources/webkits/low-priority-prescribing/.[1,2]

Savings

In England and Wales, over £65 million is spent on products in the PROP-List (NHSBSA August to October 2020). If prescribing were changed in line with recommendations, there is the potential to save over £18.3 million. This could be invested in treatments representing better value for money. As with all changes to a person's treatment, individual consideration is needed to determine the most appropriate course of action.

The PrescQIPP PROP-List

Table 3 names the products in the PROP-List and gives details of the spend in England and Wales for each item.

Table 4 is an alphabetical list of the products which considers how their use might be reviewed in the context of the evidence base and guideline recommendations. It includes commissioning recommendations for CCG/HB/ICSs to consider adopting locally.

Table 3. Annual spend on items in the PROP-List in England and Wales (NHSBSA August to October 2020)

No.	Item (* denotes those that have not featured in previous versions of the DROP-List)	Annual spend (England and Wales)
1	Lymphoedema garments	£19,898,428
2	Rectal irrigation systems	£19,767,328
3	Alimemazine*	£7,781,768
4	Ostomy underwear	£3,759,356
5	Dry mouth products	£3,092,864
6	Inhalation solutions	£1,819,164
7	Antifungal nail paint	£1,544,748
8	Eflornithine cream	£1,345,440
9	Safety needles and safety lancets	£1,153,456
10	Deodorant (stoma)	£1,139,316
11	Nasal products	£975,964
12	Plantar pressure offloading device	£924,176
13	Complementary therapies (excluding herbal products, homeopathy, and lutein and antioxidant vitamins)	£861,981
14	Waterproof limb covers*	£642,476
15	Cannabis sativa (Sativex®)	£432,340
16	Oscillating positive expiratory pressure device	£164,264
17	Insert for female stress incontinence	£124,312
18	Potassium hydroxide solution	£57,216
19	Synovial fluid*	£46,768
20	Belladonna adhesive plaster	£26,216
21	Cycloidal vibration accessories (Vibro-pulse® accessories)	£18,712
22	Needle-free insulin delivery system	£18,012
23	Pulsed electromagnetic stimulator*	£14,180
24	Pelvic toning devices	£5,128
25	Inspiratory muscle training devices	£3,196
26	Electrical stimulating wound device (Accel-heal®)	£0
	Total NHS spend:	**£65,616,788**

Items that featured in the DROP-List (2015) and the Medical Devices DROP-List (2017) that do not feature in the PROP-List 2019 are listed in Appendix 1, with their reason for deletion.

Table 4. PrescQIPP PROP-List further information (indicative savings are based on average costs across a range of strengths and products)

Links are included to PROP-List/DROP-List bulletins and support materials where available.

Abbreviations key: BTS – British Thoracic Society, RCT – Randomised controlled trial, OTC – Over the counter, NICE – National Institute of Health and Care Excellence, CKS – Clinical Knowledge Summary, QALY – Quality-adjusted life year, HRQOL - health-related quality of life, ACPRC – Association of Chartered Physiotherapists in Respiratory Care.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Alimemazine	Alimemazine has a considerably higher acquisition cost than other antihistamines.[3] Pruritus and urticaria: Not recommended. Where an antihistamine is indicated, prescribers should select one that is both clinically appropriate and cost-effective. Paediatric sleep disorders (unlicensed): A local decision is needed as to whether the short-term use of alimemazine for paediatric sleep disorders (unlicensed) is supported, where other measures have been unsuccessful or are contraindicated.	Paediatric sleep disorders: Clinical evidence is extremely limited. Where studies are available, they are small and of short duration, with mixed results.[7] Many subjects included were under 2 years old, which is not representative of modern practice. Alimemazine is contraindicated in children less than 2 years of age due to the risk of marked sedation and respiratory depression.[8] The British Association for Psychopharmacology recommend trying behavioural strategies first in children with disturbed sleep. Antihistamines are not included in their recommendations for children with sleep problems.[9] Children are more susceptible to side-effects with alimemazine.[10]	Clinical Knowledge Summaries are available for Urticaria and for Itch–widespread. In children with ADHD and in children with autistic spectrum disorder, NICE recommend non-pharmacological interventions (e.g. sleep hygiene and behavioural therapy) first-line for sleep problems.[11,12] Alternative antihistamines: promethazine is licensed for short-term use as a paediatric sedative in children (from two years of age).[13] However, clinical trial evidence for this indication is lacking.[14] As with alimemazine, there is a risk of side-effects, which children are more susceptible to.[10]	**£2,334,530** annually Assuming a 30% reduction in prescribing.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Antifungal nail paint Includes: Amorolfine nail lacquer, available as OTC and prescription only presentations Tiaconazole paint, prescription only	Where treatment of fungal nail infection is indicated, systemic treatments are more effective,[10] but they carry a greater risk of side-effects.[15,16] Adults ≥18 years old that want to topically treat a mild infection (distal and lateral subungual onychomycoses limited up to 2 nails)[17] should generally be advised to purchase antifungal nail paint OTC. Specialist advice should be sought when treating children with fungal nail infections.[18] Amorolfine lacquer is not licensed in children.[19] If it is recommended, it can only be obtained via a prescription.	In the absence of co-morbidities that increase the risk of complications, mild fungal nail infection that does not cause discomfort or distress may not need treatment.[20] People with underlying conditions that predispose them to fungal nail infections / complications should be referred to a doctor. Such conditions include peripheral circulatory disorders, diabetes mellitus, and immunosuppression.[18,20]	Purchase OTC where appropriate. Where prescribed, do not issue monthly prescriptions. A 3ml bottle of amorolfine nail lacquer may last for six months.[21] Patient information, including self care advice on fungal nail infections is available from: The British Association of Dermatologists NHS Choices	**£1,235,800** annually Assuming an 80% reduction in prescribing.
Belladonna adhesive plaster	Not recommended; there is insufficient evidence to recommend the use of belladonna adhesive plasters. Prescribing on FP10 should be discontinued. Those prescribed belladonna adhesive plasters should have their therapy reviewed. Consider recommending or prescribing an effective alternative treatment if appropriate. Do not initiate new prescriptions for belladonna adhesive plasters.	Belladonna liniments and plasters have been used as counter-irritants for the relief of pain but there is little evidence that they have a beneficial effect and adverse effects have occurred.[22]	The recommendations are consistent with national recommendation on topical rubefacients, which have also been used topically for pain relief as counter-irritants. However evidence supporting their use is also lacking. NICE state that rubefacients should not be offered for treating osteoarthritis.[23] Guidance from NHS England classifies rubefacients as items which should not be routinely prescribed in primary care.[2] Patient information about managing back pain, sciatica and neck pain can be found at: https://www.nhs.uk/conditions/back-pain/ https://www.nhs.uk/conditions/sciatica/ https://www.nhs.uk/conditions/neck-pain-and-stiff-neck/	**£20,973** annually Assuming an 80% reduction in prescribing.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Cannabis sativa, THC:CBD spray (Sativex®) (THC - delta-9-tetrahydro--cannabinol) (CBD - cannabidiol) This section relates to Sativex® only, and not other cannabis-based products.	Licensed for moderate to severe spasticity in adults with multiple sclerosis. NICE recommend a trial of THC:CBD spray, initiated and supervised by a specialist, if: • Other pharmacological treatments are not effective (see CG186 for options) • The company provides treatment according to its pay-for-responders scheme.[24] Only continue if there is a ≥20% reduction in spasticity-related symptoms.[24] Arrangements for prescribing, review and monitoring (initial and ongoing), and for funding will need to be agreed via a local process before implementation. Neuropathic pain (unlicensed) - Do not start Cannabis sativa to treat neuropathic pain in non-specialist settings, unless advised to do so by a specialist.[25] Chronic pain - CBD:THC should not be offered for the management of chronic pain in adults.[24] This applies to certain other cannabis-base products also – see NG144. People who started treatment before the guidance was published should be able to continue treatment until they and their NHS clinician think it appropriate to stop.[24]	Multiple sclerosis - Previous NICE guidance did not recommend Sativex® prescribing. Some benefits were reported in the studies reviewed by NICE, but the cost-effectiveness evidence did not support its use.[26] For the new NICE guidance on cannabis-based medicinal products the economic model found that treatment would offer sufficient QALY gains if reduction in spasticity led to a halving of management costs and the acquisition cost of the product was reduced.[24] Neuropathic pain (unlicensed) - In NICE's analysis for CG173, Sativex® appeared consistently worse than other treatments at relieving pain, and the health economic model provided no support for its use.[25] Chronic pain - The NICE evidence review included CBD in combination with THC, THC alone, dronabinol and nabilone. Some evidence showed a modest treatment effect. However the high and ongoing cost of products meant they were not considered an effective use of NHS resources.[24]	Alternatives as per the relevant NICE guideline. Moderate to severe spasticity in adults with multiple sclerosis e.g. baclofen, gabapentin, dantrolene, tizanidine, benzodiazepines.[26] Neuropathic pain e.g. amitriptyline, duloxetine, gabapentin or pregabalin[25] Chronic pain see BNF treatment summary https://bnf.nice.org.uk/treatment-summary/pain-chronic.html	Prescribing should be monitored. Spend may increase, depending on local guidance.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Complementary therapies (excluding herbal products, homeopathy, and lutein and antioxidant vitamins) Category includes unlicensed nutritional supplements (e.g. evening primrose oil, coenzyme Q10) and aromatherapy oils, that are not addressed in the NHS England guidance.[2]	Not generally recommended for prescribing; products have largely not been adequately evaluated in clinical studies. Complementary therapies may occasionally be used as part of a mainstream service care plan, or by prior approval on a case by case basis outside of this.[27] Where people wish to purchase products such as unlicensed supplements for self care, it may be appropriate to seek the advice of a healthcare professional first, particularly if they are already taking medicines or have a health condition. Community pharmacists can provide advice and refer people to their GP if necessary (see 'Suggested alternatives/ comments').	Several NICE guidelines mention complementary therapies, often with regard to the lack of evidence to support their efficacy (e.g. CG57 on managing eczema in children, NG123 on managing urinary incontinence in women).[28,29] CG181 on cardiovascular disease advises against offering coenzyme Q10 to increase statin adherence.[30] Public Health Wales guidance on interventions not normally undertaken states that complementary medicines/ alternative therapies are generally not used by the NHS. It states that the evidence suggests that there are large numbers of complementary and alternative therapies that have not been subject to the trials used to establish the effectiveness of conventional clinical treatments.[27]	It is important for health care professionals to explore the reasons that a person wishes to use a complementary therapy. People wishing to purchase this type of product for self care should be advised that: • Clinical evidence showing a benefit is often lacking or inadequate. • Taking supplements is not risk-free and there may be potential for adverse-effects or interactions with other medicines. • They should be purchased from a reputable source to help ensure product quality. • Pregnant women should not assume that complementary therapies are safe. NICE advise that they should be used as little as possible during pregnancy.[31]	**£861,981** Assuming a 100% reduction in prescribing

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Cycloidal vibration accessories (Vibro-pulse® accessories)	Not recommended; there is currently insufficient evidence to recommend the use of cycloidal vibration therapy.[32,33]	Cycloidal vibration (CV) therapy with Vibro-Pulse® is promoted as a therapy for cellulitis, venous leg ulcers and lower limb oedema. A small prospective, company- sponsored, non-blinded, randomised controlled trial (n=36) of Vibro-Pulse® in the management of cellulitis has been published. The hospital based study compared standard therapy (intravenous or oral antibiotics plus bed rest) to standard therapy plus CV therapy three times daily. A difference in full recovery within seven days favouring CV therapy was reported (67% in the intervention group vs. 11% in the control group).[34] A Cochrane review of treatments for cellulitis concluded that there was insufficient evidence on CV therapy to form a conclusion about the efficacy of such treatment.[32] No comparative trials for CV therapy for venous leg ulcers or other wounds have been identified.	See the Trent Medicines Information Service summary on Vibro-Pulse® for cellulitis and venous leg ulcers for further information.[33] The device itself is not prescribable on FP10, but the disposable covers are.	**£14,970** annually Assuming an 80% reduction in prescribing.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Deodorant (stoma)	Not recommended for routine use; deodorants should not be required. If correctly fitted, no odour should be apparent except when bag is emptied or changed. Household air-fresheners are sufficient in most cases and are widely available to buy. If odour is present at times other than changing or emptying, refer the individual for review.[35] Prescribing may be considered where it is deemed to be clinically necessary by a specialist stoma nurse, after individual review. The reason why household air-fresheners are insufficient must be documented. Do not add to repeat prescribing systems.	It is recognised that stoma nurses may occasionally recommend prescribed deodorant products for specific clinical problems, e.g. deodorant lubricant drops for 'pancaking' (where stool sits at the top of the bag), which can lead to leaking of the appliance and subsequent skin issues.[36]	Requests for prescriptions for items seen in magazines or received as samples should not be processed unless an individual review has been undertaken by a stoma care nurse and the product has been assessed as being clinically indicated.[37]	**£911,453** annually Assuming an 80% reduction in prescribing.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Dry mouth products	Dry mouth products such as artificial saliva or salivary stimulants should only be prescribed for more severe dryness, if simple measures alone are inadequate.[38,39] Where known, address the underlying cause (including drug causes) where possible/clinically appropriate. Initiate dry mouth products as a trial and discontinue if no perceived benefit. In dentate people, artificial saliva should: • Be of neutral pH (acidic pH can cause dental caries). • Ideally contain fluoride (otherwise a daily fluoride mouthwash is also needed).[39,40] See UKMi Q&A on saliva substitutes for further details.	Dry mouth products such as sprays, lozenges, mouth rinses, gels, oils, chewing gum or toothpastes have been evaluated in a Cochrane review. No strong evidence was found to support efficacy in relieving the sensation of dry mouth. Chewing sugar-free gum appears to increase saliva production in those with residual secretory capacity and may be preferred by patients, but there is no evidence that gum is better or worse than saliva substitutes.[41] Dry mouth products generally have an accepted role based on the clinical experience of experts.[38,39]	Simple measures for managing dry mouth include: • Regular sips of water • Sucking on ice cubes or ice lollies • Sucking sugar-free sweets or chewing sugar-free gum • Applying petroleum jelly on the lips if they are dry. However, if a person is on oxygen apply a water-soluble lubricant (e.g. example K-Y Jelly®).[38,42] • Avoiding alcohol, caffeine and smoking; all make dry mouth symptoms worse.[42] Good oral hygiene to avoid dental problems is essential. Some dry mouth products are borderline substances (for those with dry mouth due to radiotherapy or sicca syndrome – endorse 'ACBS'). Products can be purchased from a pharmacy; most cost the same or less than a prescription charge.	**£618,573** annually Assuming a 20% reduction in prescribing (ensuring simple measures are first line, stopping if no perceived benefit).
Eflornithine cream	Self-funded cosmetic treatments for reduction in hair growth or hair removal (e.g. shaving, plucking, laser treatment, electrolysis) should be the primary options for the majority of women with hirsutism. Several areas do not routinely fund eflornithine cream on the basis that it is a cosmetic treatment, and/or because of the limited evidence base.[43]	Clinical evidence supporting eflornithine cream is limited.[44,45] There is no evidence of its efficacy compared with existing treatments and it is comparatively expensive. The Scottish Medicines Consortium has accepted eflornithine cream for restricted use in women for whom alternative drug therapy for facial hirsutism is ineffective, contraindicated or considered inappropriate.[46]	It is important that individuals with hirsutism are properly assessed so that any underlying causes are addressed.[45]	**£1,076,352** annually Assuming an 80% reduction in prescribing.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Electrical stimulating wound device (Accel-Heal®)	Not recommended; there is currently insufficient evidence to recommend the use of the Accel-Heal® electrical stimulating device.	A company sponsored, placebo-controlled RCT (n=99) investigated the clinical and cost-effectiveness of Accel-Heal® (versus an identical-looking placebo device), in treating non-healing venous leg ulcers (VLUs) in the UK. No statistically significant differences between the Accel-Heal® group and the placebo device group were found for any of the clinical outcomes (including wound healing) or the patient reported outcomes (including pain).[47] Further data are limited and include a small unblinded, non-randomised study (n=30 wounds), and some small, uncontrolled evaluations.[48-50] The results of two small, local evaluations in NHS Scotland suggest that Accel-Heal® is associated with improved wound healing and a reduction in pain for individuals with non-healing VLUs.[51]	Accel-Heal® is the only electrical stimulating wound device listed in the Drug Tariff and costs £240 for six units.[3] An Innovative Medical Technology Overview on Accel-Heal® for the management of non-healing venous leg ulcers is available from Healthcare Improvement Scotland/SHTG. It notes that Accel-Heal® may be an effective adjunct treatment for managing patients with non-healing VLUs and those who are unable to use standard treatment, but that large, well-designed randomised controlled trials assessing relevant clinical, safety, cost and patient outcomes for longer periods are needed.[51]	Current spend is nil.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Inhalation solutions (appliances/ devices) Only hypertonic sodium chloride solutions are discussed here. Note that this section of the Drug Tariff also contains sodium chloride 0.9% nebuliser solution products classed as medical devices (which should not be mixed with any drugs).	Use outside of hospital may be considered for those with cystic fibrosis (CF) or non-CF bronchiectasis, where recommended and initiated by a specialist. Follow local guidance. Initiation (with a bronchoconstriction trial) should be done by an appropriate professional to ensure safety and suitability for the individual.[52]	CF: NICE recommend considering nebulised hypertonic saline as a 2nd line mucoactive agent in those with clinical evidence of lung disease.[53] A Cochrane review on use in non-CF bronchiectasis was unable to draw firm conclusions from the data.[54] BTS guidance (2018) on the management of bronchiectasis in adults states that the evidence for hypertonic saline suggests that it may improve QoL outcomes and sputum clearance in individuals with bronchiectasis, however it is unclear if this benefit is over and above that of isotonic saline.[55]	Hypertonic sodium chloride should be nebulised prior to airway clearance. Where it is prescribed for administration more than twice daily, confirm that the frequency matches the number of airway clearance sessions. Products come in 4ml vials. Doses greater than 4ml (e.g. 5ml) that necessitate the use of two vials per session should be queried as costs are doubled for uncertain additional benefit. Query prescriptions for hypertonic saline as an unlicensed special rather than the commercially available preparations, which are preferable where suitable. When making formulary decisions, policy makers should consider the cost difference in primary care of the available 7% strength products (and the 3% or 6% products, where lower strengths are clinically indicated).	**£181,914** annually Assuming a 10% reduction in costs (due to medicines optimisation). This figure could be greater if unlicensed specials are being prescribed.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Insert for female stress incontinence	Not recommended; there is currently insufficient evidence to recommend the use of these devices for female stress incontinence. NICE do not recommend their routine use.[29] Do not advise women to consider such devices other than for occasional use when necessary to prevent leakage, for example during physical exercise.[29] Side-effects reported in clinical trials include urinary tract infections,[56, 57] vaginal bleeding,[57,58] and discomfort.[58]	NICE guidance on urinary incontinence (UI) in women recommend that intravaginal or intraurethral devices should not be used for the routine management of UI. They state that women should not be advised to consider such devices other than for occasional use (e.g. during physical exercise).[29] A 2014 Cochrane review of mechanical devices for UI in women stated that there is little evidence from controlled trials on which to judge whether their use is better than no treatment and large well-conducted trials are required for clarification.[59] Evidence for the Contiform® device is extremely limited and includes two small case series (n=41 and n=37 that completed the protocol).[56, 60] A small RCT of the Diveen® device (n=55) reported a significant difference favouring the device for incontinence episodes frequency (IEF). However the Cochrane review above states that the IEF in this study was not significantly reduced (mean difference -24.10, 95% CI -49.60 to 1.40).[57] An RCT of the Efemia® device randomised 97 women to either treatment with the device or standard care (control). The authors reported a 55% ($p < 0.001$) mean reduction of total leakage in the intervention group compared to the control arm. However, 22 of the 97 study participants were not included in this analysis due to discontinuation of the device (n=19) or being lost to follow-up (n=3).[58]	The following devices are listed in the Drug Tariff:[3] Efemia® - £44 Diveen® - £38 Contiform® - £26.31 The above devices are all of different designs. They are all intravaginal devices. No intraurethral devices are listed in the Drug Tariff.[3] Note that the NICE evidence review (undertaken in 2013 for the guideline on UI in women)[61] focused on products that were available in the UK at the time, which differ from those currently listed in the Drug Tariff.[3] NICE advise that women with stress or mixed UI should be offered a trial of supervised pelvic floor muscle training of at least 3 months' duration as first-line treatment.[29]	**£62,156** annually Assuming an 50% reduction in prescribing.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Inspiratory muscle training devices	Not recommended for routine use, but inspiratory muscle training may be considered in those with COPD, non-CF bronchiectasis and upper spinal cord injuries.[52] For other indications, commissioners should engage with local stakeholders including respiratory specialists to determine if there are circumstances in which the intervention will be offered. Criteria for use (e.g. trials of other treatments) and an approval process should be agreed where applicable. Inspiratory muscle training should be provided only after individual assessment by an appropriately skilled therapist. Treatment should not be initiated by GPs or other non-specialists. Some devices are promoted for fitness/ sports use. In these circumstances the device should be purchased rather than prescribed.	Cochrane reviews on inspiratory muscle training for asthma, for CF and after stroke found insufficient evidence to either support or refute any benefit for the intervention.[62-64] Some evidence of benefit was found in people with cervical spinal cord injury and in people with multiple sclerosis (low quality evidence in multiple sclerosis).[65,66] In a 2012 evidence update on COPD, NICE identified evidence that appears to show benefit with inspiratory muscle training when used as the sole physical training modality, but they state that more evidence is needed, particularly in relation to which subgroups of patients would benefit the most.[67] Joint Guidance produced by BTS and ACPRC in 2009*, recommends considering inspiratory muscle training in those with COPD, non-CF bronchiectasis and upper spinal cord injuries. The guidance also states that there is insufficient evidence to support or refute the use of these devices for patients with either CF or asthma and that further research is required.[52] The statement on asthma is consistent with SIGN/BTS guidance on asthma.[68] Inspiratory muscle training is not recommended as a routine adjunct to pulmonary rehabilitation, but after assessment by a respiratory physiotherapist could be considered as an adjunct for individual patients.[69] *N.B. The BTS classify this guidance as archived as it is greater than five years old.	Three inspiratory muscle training devices are listed in the Drug Tariff:[3] POWERbreathe® Medic - £17.90 Threshold IMT® - £11.50 Ultrabreathe® - £10.95	Dependent on local pathways and whether prescribing is via primary or secondary care.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Lymphoedema garments	Ensure the use of lymphoedema compression garments is part of a local pathway. They should only be prescribed after a full assessment of the individual by an appropriately trained practitioner.[70] All reasonable steps to ensure the correct items are ordered should be undertaken. If uncertain; confirm items with the lymphoedema service before they are ordered, to avoid wastage. Provide two of each garment (one to wear, one to wash).[70] Replace every three to six months, or when they begin to lose elasticity.[70] The person should be re-measured first.[71]	Lymphoedema garments are often used in the long-term phase of lymphoedema management, usually following a period of intensive therapy (which may include multi-layer lymphoedema bandaging). They are also sometimes used as part of the initial treatment, or for prophylaxis.[70] Lymphoedema as a complication of advanced breast cancer: NICE advise considering multilayer lymphoedema bandaging for volume reduction as a first treatment option before compression hosiery. People should be provided with at least two suitable compression garments of the appropriate class and size, when their use commences. A choice of fabrics and colours should be available.[72] Liposuction for chronic lymphoedema guidance: NICE note the role of compression garments in the conservative treatment of lymphoedema. Custom-made compression garments also need to be worn after this procedure.[73]	It can be difficult to identify the intended lymphoedema garment on GPs prescribing systems. Although these are coded according to the Dictionary of Medicines and Devices (dm+d), commonly used GP prescribing systems do not always recognise the correct dm+d codes. Lymphoedema garments can be expensive so it is important that checks and processes are in place for ordering the correct item to prevent the wrong garment being prescribed. Garments should be washed frequently according to the manufacturer's instructions.[70] See Bulletin 192 on Lymphoedema compression garments for further information.	**£3,979,685** annually Assuming a 20% reduction in prescribing (by reducing wastage, but note that it is not possible to tell what proportion of the annual spend is due to the incorrect item being ordered). Implementing new services where provision has previously been poor could lead to an increase in spend on lymphoedema garments. However, savings may be achieved by reducing complications and morbidity, e.g. cellulitis, unplanned hospital admissions.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Nasal products (The majority of prescribing is for proprietary saline nasal sprays, e.g. Sterimar®, Aqua Maris®).	Not recommended for prescribing. Managing the nasal symptoms of self-limiting conditions: Saline nasal sprays can be purchased OTC for self care by those that wish to try them. It should be explained that there is not enough evidence to show they relieve nasal congestion and recommend their use.[74] For chronic rhinosinusitis: large volume saline douches are thought to be more effective than saline nasal sprays.[75-77]	Acute sinusitis: NICE and Cochrane found low quality evidence of a statistically significant reduction in nasal symptom scores in children aged 6-10 years, but the improvements may not have been clinically important.[74,78] Allergic rhinitis: There is low or very low quality evidence that saline irrigation may reduce patient-reported disease severity compared with no saline irrigation in the short-term.[79] Chronic rhinosinusitis: There is evidence to support the use of large volume saline nasal irrigation in the management of chronic rhinosinusitis, but it is generally of poor quality.[80, 81] Large volume saline douches are thought to be more effective than nasal sprays.[75-77]	Health care professionals recommending nasal douching should ensure they are familiar with the procedure so that they can advise people of an appropriate and safe method to use. Information for health care professionals on nasal douching is available on the British Society for Allergy and Clinical Immunology (BSACI) website: see SOP on nasal douching. The document above from the BSACI also notes that using a proprietary product for children under twelve years or adults that are unsure may make nasal douching more acceptable and safer where there is uncertainty about mixing up a homemade solution.[82]	**£780,771** annually Assuming an 80% reduction in prescribing by recommending self care or the use of large volume saline douches instead, where clinically appropriate.
Needle-free insulin delivery system	Not routinely recommended unless there is a confirmed diagnosis of needle phobia which would result in the person not injecting insulin. Where use is deemed to be appropriate, treatment should be initiated and stabilised by an appropriate specialist. Follow local guidance.	NICE advise that adults with type 1 diabetes who have special visual or psychological needs be provided with injection devices or needle-free systems that they can use independently for accurate dosing.[83] Limited data from two small pharmacokinetic studies in healthy volunteers (n=18)[84] and people with diabetes (n=24)[85] have demonstrated some pharmacokinetic differences in insulin aspart delivered via Insujet® compared with conventional pen injection. Careful monitoring of blood glucose levels is therefore needed in people switching to a needle-free insulin delivery method.[86]	Needle-free insulin delivery systems use jet injector technology to fire a jet of insulin at high velocity into the subcutaneous region.[86] They are a possible option for people with true and severe needle phobia (which is rare).[87] Two needle-free delivery systems are listed in the Drug Tariff: Injex® and InsuJet®. However, the UK distributors of Injex® have ceased trading so there is currently no UK distributor for this product.[88] New devices are in development, however it is not known if and when they will be available in the UK market.	Dependent on local pathways and whether prescribing is via primary or secondary care.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Oscillating positive expiratory pressure device (OPEP device)	Recommended for consideration when selecting an appropriate airway clearance technique (ACT) for those with CF[52] and non-CF bronchiectasis.[52,55] Recommended as an option under physiotherapy in the NICE COPD guideline. People with COPD who have excessive sputum should be taught how to use positive expiratory devices.[67] For non-CF bronchiectasis commissioners should be aware that the supporting evidence is much more limited and considered to be low quality.[89,90] They should engage with local stakeholders including respiratory specialists to determine in what circumstances treatment with oscillating positive expiratory pressure (OPEP) is to be offered. Criteria for use (e.g. disease severity, prior trials of other treatments) and an approval process should be agreed where applicable. OPEP treatment should be provided only after individual assessment by an appropriately skilled therapist. Treatment should not be initiated by GPs or other non-specialists. Although several devices may be required per year, they should not be added to repeat prescribing systems.	A Cochrane review of oscillating devices in people with CF (n=1114) found no clear evidence that oscillation was more or less effective overall than other forms of physiotherapy.[94] There was also no evidence that one device is superior to another.[91] A systematic review (n=146) assessed OPEP compared with other airway clearance techniques or control in people with stable non-CF bronchiectasis. OPEP resulted in greater sputum expectoration than no treatment, but did not reduce exacerbation rate. Effects on sputum expectoration, lung function, gas exchange and symptom relief, appeared to be equivalent to other ACTs.[89] A Cochrane review comparing PEP therapy to other airway clearance techniques in people with bronchiectasis (n=213) concluded that they had similar effects on HRQOL, symptoms of breathlessness, sputum expectoration, and overall lung function. The number of studies and the overall quality of the evidence were low.[90] Joint Guidance produced by the BTS and ACPRC in 2009, but now considered archived as it is greater than 5 years old, recommended considering oscillating PEP when selecting an airway clearance technique for those with CF[56] and non-CF bronchiectasis and for patients with COPD who need a device to assist with removal of secretions.[52,55]	The manufacturer's washing and replacement advice should be followed for each device. The following OPEP devices are listed in part IXA of the Drug Tariff:[3] Other products are available but cannot be prescribed on an FP10 unless listed in the Drug Tariff. Acapella® – £40.50, estimated device lifetime six months.[92] Aerobika® - £45.50, replace after 12 months of use or immediately if damaged.[93] Flutter® - £40.50, several probably needed each year with regular use.[94] Lungflute® - £37.50, replace reed about every two weeks.[95] Pari O-PEP – £27.28, replace device at least once a year or after 300 disinfection cycles. See directions for use for more information.[96] RC-Cornet® - £39.95, replace silicone valve tube every six months.[97] RC-Cornet Plus® - £38.53, replace silicone tube every six months.[98]	Dependent on local pathways and whether prescribing is via primary or secondary care.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Ostomy underwear	Parastomal hernia prevention: Not recommended for routine prescribing. Specific ostomy underwear is not generally necessary, as high waisted support underwear (with Lycra®) is readily available from high-street stores, or can be purchased from specialist ostomy manufacturers if preferred.[99] The exception is where a clinical need is identified, e.g. • Where a stoma nurse recommends a garment with a higher level of support because of risk factors present. • Where the stoma nurse or GP feel that prescribing of a lightweight support garment is necessary for comfort and discretion due to significant psychosocial impact affecting the person's wellbeing. The route of approval for prescribing in these circumstances should be defined locally. Parastomal hernia management Support ostomy underwear/ garments should be prescribed where recommended by a stoma nurse.[99] Do not add to repeat prescribing systems.	Supporting evidence for use in parastomal hernia prevention is limited. It includes two small studies (neither were RCTs) showing that prevention programmes including the use of abdominal support belts or garments after stoma surgery, along with core exercises and education, may reduce the incidence of parastomal hernias.[100,101] In one study support belts were only used for heavy work, rather than worn routinely.[100] For prevention, the Association of Stoma Care Nurses (ASCN) recommend that stoma nurses identify predisposing factors for parastomal hernias and provide education and prevention advice, including: • Hernia prevention exercise information. • Advice to purchase lightweight support underwear from a high street store or obtain a prescribed garment if necessary.[99] Those at higher risk should be advised of how to reduce their risk where possible (e.g. smoking/weight/lifestyle). A higher level of support garment should be considered as per the local policy.[99]	Support wear should not be viewed as a stand-alone intervention. The limited supporting evidence used a package of hernia prevention measures, which also included education, core exercises and regular follow-up.[100,101] It has been noted that adherence to the wearing of hernia support garments can be poor. Education, along with correct measurement and fitting of garments by an appropriately trained practitioner may be important in improving adherence and reducing waste.[102] Where prescribing is appropriate, suggested maximum quantities are: • three belts per year • three girdles per year • six pairs of briefs or boxers per year.[99]	**£1,127,807** annually Assuming a 30% reduction (by stopping prescribing ostomy underwear for prevention, and prescribing products only when recommended by a specialist stoma nurse). There could be a large variation in potential saving depending on current local practice.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Pelvic toning devices	Not recommended for prescribing; there is no evidence of additional benefit compared to undertaking pelvic floor exercises alone. Those that wish to use pelvic toning devices may purchase them from a pharmacy or on-line.	Several NICE guidelines, including those on urinary incontinence (UI) in women, faecal incontinence, UI in neurological disease, antenatal care and lower urinary tract symptoms in men make recommendations about pelvic floor exercises.[31,103-105] A Cochrane review investigating weighted vaginal cones for UI found some evidence, from mainly small trials, that cones are better than no active treatment in women with stress UI. However, no clear differences were evident when vaginal cones/weights were compared with other treatments, such as pelvic floor muscle training alone (i.e. exercises without the devices).[106] A small trial (n=40) investigated the use of the Pelvic Toner® device in women with stress UI, to aid pelvic floor muscle training (n=28), compared with standard pelvic floor muscle training alone; (n=24). The primary outcome was subject reported improvement and defined as positive change. At 16 weeks, no significant difference between the groups regarding improvement in stress UI was seen.[107]	Pelvic toning devices are either egg or cone shaped devices that are inserted into the vagina to assist with pelvic floor exercises. They can be weighted devices (e.g. Kegel8® and Aquaflex®) or incorporate a hinge and spring mechanism to provide passive resistance (Pelvic Toner®). Several pelvic toning devices are available, but only three are listed in the Drug Tariff:[3] Aquaflex® - £13.95 Kegel8® - £15.00 Pelvic Toner® - £15.00	**£4,102** annually Assuming an 80% reduction in prescribing.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Plantar pressure offloading device	Ensure the use of plantar pressure offloading devices is part of a robust and clear local pathway for the prevention and management of diabetic foot problems. Plantar pressure offloading devices should only be prescribed after individual assessment by an appropriately skilled practitioner. This is likely to be via a foot protection service or a multidisciplinary foot care service. When deciding about offloading, the clinical assessment of the wound and the person's preference should be taken into account, and the devices with the lowest acquisition cost appropriate to the clinical circumstances should be used.[108] Prescribable plantar pressure offloading devices are reusable and should not be added to repeat prescribing systems.	NICE advise that those with diabetic foot problems should be referred to a foot protection service or a multidisciplinary foot care service.[108] Foot care services may recommend offloading of plantar pressure for diabetic foot ulcer treatment, or where there is suspicion of acute Charcot arthropathy.[108] They may also consider the need for preventative use of specialist footwear and orthoses in those at moderate or high risk of developing a diabetic foot problem.[108] Non-removable casts are more effective in healing diabetes related plantar foot ulcers than removable casts.[109] They are the preferred option, where clinically appropriate.[108,110] Removable offloading devices may be needed in the following circumstances: Until casting can be provided.[108] Where it is more appropriate for the person's clinical or personal circumstances (e.g. where ischaemia or infection are present).[108,110]	The following plantar pressure offloading devices are listed in the Drug Tariff:[3] BeneFoot® Medical Shoe - £12.99 to £16.99 Cellona® Shoe - £16.40 Kerraped® All Purpose Boot - £17.92 Kerraped® Plantar Ulcer Shoe System - £58.27 (£26.94 for replacement liner) Kerraped® Plus All Purpose Boot - £19.50 Liqua Care® Diabetic Flowgel - £17.95 Liqua Care Orthotics® - £17.45 VACOcast® Diabetic - £149.00 Other removable plantar pressure offloading devices are available.[110] However only those listed in the Drug Tariff can be provided via prescription.	**£92,418** annually Assuming a 10% reduction in prescribing (by ensuring local pathways govern appropriate use).

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Potassium hydroxide solution for treating molluscum contagiosum (MolluDab® 5% and Molutrex® 5%).	Not recommended in primary care.[111] There is currently insufficient evidence of efficacy and a risk of side-effects. Molluscum contagiosum does not usually require treatment in immunocompetent people.[111] There are some circumstances where specialist referral is indicated; including where lesions continue to be troublesome, are extensive or where there is diagnostic uncertainty.[111] Urgent referral should be considered for extensive problematic lesions in children, a person is known to be immunocompromised, eyelid margin or ocular involvement, HIV positive patients, or adults with anogenital lesions.[111] See the NICE CKS Summary for further information. A specialist may consider the use of potassium hydroxide solution, but other treatment options may be available.[111]	Unless there is an indication for urgent referral, NICE-CKS recommend giving reassurance that molluscum contagiosum is a self-limiting condition that usually resolves spontaneously within 18 months in otherwise healthy individuals. Advice to avoid sharing towels, clothing and baths, and to avoid scratching the lesions should also be provided. Exclusion from school, gym or swimming is not necessary.[111] A Cochrane review investigating interventions for molluscum contagiosum in people without immune deficiency concluded that no single intervention has been shown to be convincingly effective.[112] Potassium hydroxide is caustic. Burning or stinging is the most common adverse effect. Other effects included erythema, itching, pain, erosion, crusting and hyperpigmentation.[113]	MolluDab® 5% (£13.50) and Molutrex® 5% (£10.13) are listed as appliances in Part IXA of the Drug Tariff.[3] Information for patients on molluscum contagiosum can be found on the NHS website. The British Association of Dermatologists produce a range of patient information leaflets, including one, on molluscum contagiosum.	**£45,774** annually Assuming an 80% reduction in prescribing.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Pulsed electromagnetic stimulator (ActiPatch®)	Not recommended for routine prescribing; evidence for ActiPatch® is yet to be evaluated by a national body. The scope for the update to CG177 on the care and management of osteoarthritis, NICE includes a review on electrotherapies (including this type of device) which may impact on the guideline.[114]	RCT evidence for ActiPatch®, in musculoskeletal pain includes two small double-blind RCTs, one (n=60) comparing ActiPatch® with placebo in people with osteoarthritis of the knee and persistent pain, and another (n=70) comparing ActiPatch® with placebo in plantar fasciitis. Both studies demonstrated a statistically significant reduction in pain scores favouring ActiPatch®. Both studies are limited by their small size and short duration.[115-117] More recently, a small, short term RCT (n=200) compared the effect of 4 weeks of treatment with either Actipatch® or etoricoxib 60mg daily on the disability and pain caused by cervical osteoarthritis. After 4 weeks of treatment, subjects in both study arms reported statistically significant ($p < 0.0001$) reductions in scores on the Neck Disability Index (a primary outcome) pain scores at rest and during physical activity (secondary outcomes). [118]	A number of PrescQIPP resources relating to pain and its management are available at www.prescqipp.info	Current spend is low - £14,180 annually.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Rectal irrigation systems (Rectal irrigation is also known as anal irrigation or trans-anal irrigation).	Rectal irrigation is a specialist management option. Where treatment is considered appropriate, it should be offered as part of a supportive bowel care programme. People using rectal irrigation should have training and ongoing support from a specialist health care professional.[119] Rectal irrigation may not be suitable for all people with bowel dysfunction,[119] and should only be considered if other less invasive methods of bowel management have failed to adequately control constipation and/or faecal incontinence. This can include dietary measures, adjusting fluid intake, bowel habit, ensuring toilet access, evacuation techniques, medication and pelvic floor muscle training.[120]	RCT evidence supporting rectal irrigation is limited to one study (n=87), undertaken in adults with neurogenic bowel dysfunction.[121] Other evidence comes from observational studies, using subjective patient reported outcomes and is generally weak and at risk of bias.[122] Faecal incontinence in adults: NICE advise considering specialised management in those that continue to have episodes of faecal incontinence after initial management. This may involve referral to a specialist continence service and rectal irrigation may be considered.[123] Peristeen® rectal irrigation system: NICE state that the evidence supports the case for adopting its use in people with bowel dysfunction. In children with bowel dysfunction, NICE state that despite limitations in the published evidence, anecdotal experience suggests that, Peristeen® may offer significant benefits.[119] Constipation in children: NICE guidance does not currently include rectal irrigation as a treatment option.[124] NICE state that there is uncertainty around the safety and efficacy of rectal irrigation in this population[125] (*See comments section for further detail).	Products should not be added to GPs repeat prescribing systems at initiation. Once a consistent routine of irrigation has been established (often on alternate days)[120] it may be appropriate to add only items that need to be ordered on a monthly basis to the repeat prescribing system. Irrigation systems can be re-used and therefore a new prescription is not needed every month, e.g. Peristeen® irrigation system has 90 uses so would last six months if the person was irrigating every other day.[120] Rectal catheters are single use and the water bag needs changing every 15 uses so the average patient will need at least one accessory unit pack per month. For those taking laxatives before starting irrigation, it is prudent to continue these in the usual dose until irrigation is established. They may subsequently be able to gradually stop taking laxatives.[120] See also PrescQIPP Bulletin 171 https://www.prescqipp.info/our-resources/bulletins/bulletin-171-rectal-irrigation-drop-list/ *After NICE published guidance on Peristeen®, they undertook surveillance of the clinical guideline on managing constipation in children (CG99), as the Peristeen® guidance could cover this population. NICE decided not to update CG99 at present, as the evidence on rectal irrigation had not substantially progressed since it was last checked, although they did acknowledge that this is an area of research showing promising results for the treatment of constipation in this population.[125]	**£3,953,465** annually Assuming a 20% reduction in prescribing (reducing wastage and any inappropriate prescribing).

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Safety needles and safety lancets	Not recommended for routine prescribing: Safety needles and lancets (also known as 'safer sharps') are primarily for the benefit of healthcare workers to avoid needle stick injury, rather than for use by patients for self-administration. Therefore they should not routinely be prescribed by GPs on FP10s.[126,127] There may be exceptions where prescribing is appropriate to ensure medication can be given/monitored safely where a person is not able to self-administer.[128]	Safer sharps are medical sharps (including insulin syringes and needles) that incorporate features or mechanisms to prevent or minimise the risk of accidental injury.[129] Under Health and Safety Executive (HSE) Regulations issued in 2013, employers must substitute traditional, unprotected medical sharps with a 'safer sharp' where it is reasonably practicable to do so.[129] To ensure that insulin can be given safely where a patient is not able to self-administer, NICE advise that staff, and where appropriate, patients who use pen devices, should be routinely provided with safety needles and access to equipment capable of safely removing and disposing of used insulin pen needles. It is essential that staff are trained to use safety needles correctly.[128]	Safer sharps are quite often more expensive than the equivalent unprotected sharp. In order to minimise the inappropriate use of safer sharps, it is recommended that CCGs agree a protocol for the implementation of the HSE regulations in collaboration with community health services.[126] For further information, see: PrescQIPP Bulletin 103: Hypodermic insulin devices for patients with type 2 diabetes PrescQIPP Bulletin 276: Cost effective lancets for blood sampling	**£922,764** Assuming an 80% reduction in prescribing.
Synovial fluid (sodium hyaluronate, hyaluronic acid, hyaluronans, hylan G-F 20) Sodium hyaluronate injections (TendoVis, SportVis) See the Drug Tariff Part IXA (appliances) for products.[3]	Not recommended; NICE guidance does not recommend offering intra-articular hyaluronan injections for the management of osteoarthritis.[130]	Current NICE guidance on the care and management of osteoarthritis does not recommend offering intra-articular hyaluronan injections (a NICE 'do not do' recommendation).[130] NICE found a lack of good quality evidence to support intra-articular injection of hyaluronan. Furthermore, the Guideline Development Group concluded that hyaluronan injections were not likely to be cost effective.[130] Note that NICE plan to update their osteoarthritis guidance, which will include a review of the section on intra-articular injections.[131]	See NICE CG177 on the care and management of osteoarthritis for management options.	**£37,413** annually Assuming an 80% reduction in prescribing.

Product	Recommendations for local consideration	National guidance and evidence	Suggested alternatives/comments	Indicative savings
Waterproof limb covers (LimbO®, Seal-Tight® and BUDDY®)	Casts on a fractured limb: Not generally recommended for prescribing; people should be advised to purchase an appropriate product if required. PICC lines: A local decision is required as to whether these should be purchased or provided (and whether provision should be via secondary care, or in primary care via FP10). Wound care (e.g. bandaged leg / foot ulcers): A local decision is required as to whether these should be purchased or provided via FP10.	Waterproof limb covers are designed to keep casts, PICC lines or dressings dry while bathing or showering (not all products are suitable for all uses). Their prescribing may be considered appropriate where they are needed for prolonged periods (e.g. in people with chronic wounds or with PICC lines), or where protection from water is recommended to reduce the risk of infection (PICC lines).[132]	Waterproof limb covers are reusable. Where prescribing is supported, they should not be placed on repeat prescription. Four brands of waterproof limb covers are listed in the Drug Tariff, in a variety of types / sizes:[3] Bloccs® - manufacturer advises wear for up to 30 minutes. Product should last for about 4 weeks of normal use.[133] LimbO® - guaranteed for 12 weeks – company will replace or refund.[134] Seal-Tight® - Reusable. Recommended product life varies with product and indication – consult manufacturer.[135] BUDDY® - manufacturer recommends wearing the cover for up to of 1.5 hour. It can be used up to 30 times).[136]	**£64,248** annually Assuming a 10% reduction in prescribing.

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Appendix 1 – Deletions

Items that featured in the DROP-List (2015) and the Medical Devices DROP-List (2017) that do not feature in the PROP-List are listed below, with their reason for deletion.

Product	Reason for deletion
Aliskiren	Covered in NHS England guidance: Items which should not routinely be prescribed in primary care: Guidance for CCGs, version 2. Issued 21/06/19.
Amiodarone	
Co-proxamol (paracetamol/ dextropropoxyphene) and Tramacet® (paracetamol/tramadol)	
Herbal supplements and homeopathy	
Dosulepin	
Doxazosin MR (Cardura® XL)	
Fentanyl immediate release formulations	
Glucosamine	
Lidocaine plasters	
Liothyronine	
Lutein and antioxidant vitamins	
Minocycline for acne	
Omega-3 fatty acids and other fish oils	
Oxycodone/Naloxone (Targinact®)	
Perindopril arginine (Coversyl® Arginine) and branded Coversyl®	
Rubefacients (excluding topical NSAIDS)	
Silk garments	
Tadalafil once daily (Cialis® once-a-day)	
Travel vaccines not prescribable on NHS	
Acne treatment (Aknicare®)	Covered in NHS England guidance: NHS England Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs. Issued 29/03/18.
Antihistamines	
Cough and cold remedies	
Dental products on FP10	
Ear wax softening medical devices	
Eye compress (for dry eyes)	
Head lice device	
Infantile colic	
Multivitamins	
Nasal sprays (OTC)	
Probiotics	
Self care – Analgesia	
Bacterial decolonisation products	Selection and prescribing of products for bacterial decolonisation should be in accordance with local guidelines.
Auto inflation device (Otovent®)	Deleted from part IX-Appliances of the Drug Tariff from 1st May 2019.

Additional PrescQIPP resources

Briefing	https://www.prescqipp.info/our-resources/bulletins/bulletin-235-prop-list/
Implementation tools	
Data pack	https://data.prescqipp.info/?pdata.u/#/views/B235_PROP-Listupdate/FrontPage?:iid=1

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