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PrescQIPP
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Low Priority Prescribing

This bulletin provides recommendations for items that should not routinely be prescribed in primary care because there are significant safety concerns, there is a lack of robust evidence of clinical effectiveness, more cost-effective interventions are available, or the item is deemed a low priority for NHS funding.

It is based on the NHS England document entitled Items which should not routinely be prescribed in primary care: policy guidance,[1] published August 2023 and last updated in October 2023.

Recommendations

- Review the list of products that represent a low priority for prescribing on the NHS and consider switching existing patients to the proposed alternatives or discontinuing prescribing, as appropriate.
- For items where no prescribing is appropriate (co-proxamol; glucosamine and chondroitin; herbal treatments and other natural products; homeopathy; minocycline for acne; omega-3 fatty acid compounds (excluding icosapent ethyl [Vazkepa®]); silk garments), do not initiate in primary care and deprescribe for existing patients.
- For items where prescribing may be appropriate in some exceptional circumstances (aliskiren; bath and shower preparations for dry and pruritic skin conditions; dosulepin; doxazosin (prolonged-release); lutein and antioxidants; oxycodone and naloxone combination product; paracetamol and tramadol combination product; perindopril arginine; rubefacients, benzydamine, mucopolysaccharide and cooling products (excluding NSAIDs and capsaicin); trimipramine), do not initiate in primary care and deprescribe for existing patients unless no other item or intervention is available or clinically appropriate.
- Ensure that patients are appropriately reviewed after changes are made to ensure appropriate management of their condition, as applicable.
- Liaise with relevant members of the team to determine an appropriate action plan for dissemination and implementation of this guidance.
- Liaise with secondary care providers (through the Integrated Care Board—ICB) to gain support for item selection and to provide patient education on item availability.
- The regional ICS dashboards have an LPP indicator that shows the prescribing across the ICS (Please note access is not included in the ICB subscription)

Supporting information

The tables over the next few pages summarise the spend and supporting evidence for these items being on the low priority prescribing list as well as suggesting alternatives. More detailed information is available in the individual product bulletins linked and available on the PrescQIPP low priority prescribing webkit

Table 1: Total annual spend for products which should not be routinely prescribed in England, the Isle of Man (NHSBSA, September to November 2023) and Scotland (Public Health Scotland, June to August 2023)

No.	Item	Total annual spend
1.	Aliskiren	£426,752
2.	Amiodarone	£806,044
3.	Bath and shower preparations for dry and pruritic skin conditions	£10.6 million
4.	Co-proxamol (paracetamol/dextropropoxyphene)	£1.8 million
5.	Dosulepin	£4.6 million
6.	Doxazosin (prolonged release)	£2.1 million
7.	Dronedarone	£1.7 million
8.	Glucosamine and chondroitin	£81,344
9.	Herbal treatment and other natural products	£994,837
10.	Homeopathy	£17,615
11.	Immediate-release fentanyl	£5.4 million
12.	Lidocaine plasters	£30.8 million
13.	Liothyronine (including Armour Thyroid and liothyronine combination products)	£11.5 million
14.	Lutein and antioxidants	£324,437
15.	Minocycline for acne	£231,206
16.	Needles for pre-filled and reusable insulin pens	£9 million
17.	Omega-3 fatty acid compounds (excluding icosapent ethyl [Vazkepa®])	£2.8 million
18.	Oxycodone and naloxone combination products	£1.8 million
19.	Paracetamol and tramadol combination products	£395,107
20.	Perindopril arginine	£785,505
21.	Rubefacients, benzydamine, mucopolysaccharide and cooling products (excluding topical NSAIDs and capsaicin)	£1.9 million
22.	Silk garments	£441,886
23.	Travel vaccines (vaccines administered exclusively for the purposes of travel)	£721,030
24.	Trimipramine	£6.4 million
Total NHS spend		**£95.9 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
1. Aliskiren	Aliskiren is not recommended for resistant (step 4) hypertension, due to insufficient clinical and cost-effectiveness data.[2] It is not included as a treatment option by NICE[2] or the SMC[3] for essential hypertension and studies looking at mortality, cardiovascular outcomes and hospitalisation for specific patient populations have found no benefit.[4,5] 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 (ARBs), especially in patients with diabetes and those with impaired renal function.[6]	Specialist initiation in patients for whom there are no alternative options or control of blood pressure is still inadequate with recommended combination therapy. Continuation in primary care should be under a formal shared care agreement.	Follow the advice in NICE NG136 on the diagnosis and management of hypertension in adults.[2]	Assuming an 80% reduction in prescribing **£328,527**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
2. Amiodarone	Amiodarone is not recommended for long-term rate control in atrial fibrillation (AF).[7] There is a risk of potentially fatal long-term side-effects, and alternative treatments are available.[7] There is a lack of evidence on long-term rate control and numerous unpredictable and serious side effects are associated with the long-term use of amiodarone (including thyroid, lung and nerve damage), many of which are irreversible.[7] Amiodarone should only be used as an interim therapy, for example while waiting for cardioversion, and would not usually be taken for longer than 12 months.[7]	Amiodarone should only be considered for the following interim therapy and should not normally be taken for more than 12 months:[7] • Rhythm control in people with left ventricular impairment or heart failure. • Pre (four weeks) and post (up to 12 months) electrical cardioversion to maintain sinus rhythm. • Pharmacological cardioversion in new onset AF. • People undergoing cardiothoracic surgery to reduce risk of post-operative AF (ongoing need to be re-assessed usually at around 6 weeks) As a result, amiodarone must be initiated by a specialist and only continued in primary care under a formal shared care arrangement.	A rate-control treatment (beta-blocker other than sotalol or rate limiting calcium-channel blocker (diltiazem or verapamil)) is recommended for most people with AF.[7] Digoxin or dronedarone may be considered in specific circumstances.[7] Flecainide may be considered for pharmacological cardioversion in new onset AF, in people with no evidence of structural or ischaemic heart disease.[7]	Assuming a 50% reduction in prescribing **£403,021**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
3. Bath and shower preparations for dry and pruritic skin conditions	The BATHE study showed no evidence of clinical benefit for 'pour in' emollient bath additives in the standard management of childhood eczema in under 12s.[8] Antibacterial-containing bath and shower emollients can also contribute to antimicrobial resistance.[9]	There may be genuine clinical circumstances when it is appropriate to prescribe. These include where the prescribing clinician considers no other medicine or intervention to be clinically appropriate and available for the individual. Soap avoidance and 'leave-on' emollient moisturisers can still be used for treating eczema and these emollients can still be used as soap substitutes. See PrescQIPP bulletin on the prescribing of bath and shower preparations for dry and pruritic skin conditions.[10] Patients should be counselled on the use of any emollients as soap substitutes and the risks of using emollients should be fully explained.[11]	Substitute with leave-on emollient. Advise to purchase bath and shower emollients over-the-counter if still desired and the lack of evidence has been discussed. Caution regarding risk of falls with bath and shower emollients as they can make surfaces slippery.	Assuming a 50% reduction in prescribing (based on switching to a leave-on emollient) **£5.3 million**
4. Co-proxamol (paracetamol/ dextropropo-xyphene)	Co-proxamol is markedly more toxic in overdose than paracetamol alone. It was fully withdrawn in 2007 due to safety concerns.[12] This has saved the lives of around 300–400 people per annum in the UK from self-poisoning of which around a fifth were accidental.[12] Any prescriptions are now unlicensed 'special-order' products ("specials").[13]	None foreseen.	Paracetamol 500mg £2.25/100 tablets.[14] Co-codamol 30/500 £3.80/100 tablets.[14]	Assuming a 90% reduction in prescribing (based on switching to co-codamol) **£1.6 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
5. Dosulepin	NICE NG222 for depression in adults states: "Do not routinely start treatment with tricyclic antidepressants as they are associated with the greatest risk in overdose".[15] Use of dosulepin in new patients should be avoided.[16] Dosulepin has a small margin of safety between the (maximum) therapeutic dose and potentially fatal dose. About 20% of fatal overdoses are unintentional.[16]	Should be prescribed only if the decision has been made after a multidisciplinary team discussion. Dosulepin should be initiated by a specialist.[16]	Selective serotonin reuptake inhibitors (SSRIs) are first-line. Where non-SSRI antidepressants are required, prescribers should follow NICE NG222.[15]	Assuming a 90% reduction in prescribing (based on switching to citalopram) **£4.2 million**
6. Doxazosin, prolonged release	There is no good evidence of additional benefit over immediate-release (IR) doxazosin.[17] Both formulations provide effective blood pressure control and are effective at controlling the symptoms of benign prostatic hyperplasia (BPH).[17] The long half-life of immediate-release doxazosin allows once daily dosing.[17]	None foreseen.	Immediate-release doxazosin:[14] 1mg tablets - £0.78/28 2mg tablets - £0.74/28 4mg tablets - £0.84/28 8mg tablets - £9.49/28 (prescribe 8mg dose as multiples of 4mg where possible)	Assuming a 90% reduction in prescribing (based on switching to IR) **£1.9 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
7. Dronedarone Continued overleaf	Due to significant safety concerns, the overall balance of risks and benefits have been reviewed for dronedarone and its use is consequently restricted to specific patient groups where the benefit continues to outweigh the risks.[18] People who do not meet these criteria who are currently receiving dronedarone should have the option to continue treatment until they and their clinicians consider it appropriate to stop.[7]	Dronedarone must be initiated by a specialist[7] and only continued under a shared care arrangement for patients where other treatments cannot be used or have failed, or use is in line with NICE guidance on atrial fibrillation. Dronedarone is only recommended as a treatment option by NICE for the maintenance of sinus rhythm after successful cardioversion in people with paroxysmal or persistent atrial fibrillation for people who fulfil all of the following criteria:[7] Atrial fibrillation is not controlled by first-line therapy (usually including beta-blockers) **And** Alternative options have been considered **And** The person has at least one of the following cardiovascular risk factors: • Hypertension requiring drugs of at least 2 different classes, • Diabetes mellitus, • Previous transient ischaemic attack, stroke or systemic embolism, • Left atrial diameter of 50 mm or greater, • Age 70 years or older.	A rate-control treatment (beta-blocker except sotalol or a rate limiting calcium-channel blocker (e.g. diltiazem or verapamil)) is recommended for most people with AF.[7] Digoxin may be considered in specific circumstances.[7]	Assuming an 50% reduction in prescribing **£877,945**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
Dronedarone (cont.)		**And** The person does not have left ventricular systolic dysfunction **And** They do not have a history of, or current, heart failure. The SMC restricts the use of dronedarone for the prevention of recurrence of AF in patients in whom beta-blockers, class 1c drugs or amiodarone are contra-indicated, ineffective or not tolerated.[19]		

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
8. Glucosamine and chondroitin	NICE states that glucosamine should not be offered to manage osteoarthritis as there is no strong evidence of benefit.[20] The SMC states that glucosamine hydrochloride is not recommended for use within NHS Scotland for relief of symptoms in mild to moderate osteoarthritis of the knee[21] and glucosamine sulphate is not recommended for use within NHS Scotland.[22,23] See PrescQIPP bulletin for more information stating that glucosamine (with or without chondroitin) is not recommended for prescribing on the NHS as the evidence to support its efficacy is not strong enough and it is not considered to be cost-effective.	None foreseen	Advise to purchase OTC if patient wants to take the supplement after understanding that there is a lack of evidence of efficacy.	Assuming a 100% reduction in prescribing **£81,344**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
9. Herbal treatments and other natural products	Under a traditional herbal registration (THR) there is no requirement to prove scientifically that a product works; the registration is based on a minimum of 30 years use of the product as a traditional medicine.[24] In addition to herbal treatments with a THR, other natural products without a THR and without robust evidence of clinical effectiveness should not be prescribed at the NHS expense. These include natural oils (e.g., eucalyptus and almond), coenzyme Q10 (ubiquinone and ubidecarenone) and evening primrose (gamolenic acid).	None foreseen	Advise to purchase OTC if patient wants to take these products after understanding that there is no requirement for the manufacturer to scientifically prove that a product works or there is a lack of safety information.	Assuming a 100% reduction in prescribing **£994,837**
10. Homeopathy	Homeopathy seeks to treat patients with highly diluted substances that are administered orally. A Specialist Pharmacy Service (SPS) review found no clear or robust evidence to support the use of homeopathy on the NHS.[25]	None foreseen	Advise to purchase OTC if patient wants to take it after understanding that that there is a lack of evidence of efficacy or there is a lack of safety information.	Assuming a 100% reduction in prescribing **£17,615**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
11. Immediate-release fentanyl	Immediate-release fentanyl is only licensed for the treatment of breakthrough pain in adults with cancer who have been receiving at least 60mg oral morphine daily or equivalent for a week or longer. Breakthrough pain is a transient exacerbation of otherwise controlled chronic background pain.[26] Fentanyl is also significantly more expensive than immediate-release morphine.[14] This recommendation does not apply to longer sustained-release versions of fentanyl, which come in patch form.	It may be prescribed only if no other item or intervention is clinically appropriate (i.e., immediate-release morphine), if no other item or intervention is available, or for palliative care treatment and where the recommendation to use immediate-release fentanyl is in line with NICE guidance,[27] and has been made by a multidisciplinary team and/or other healthcare professional with a recognised specialism in palliative care. Immediate-release fentanyl may therefore be prescribed for these patients.	Morphine sulfate oral solution 10mg/5ml. £3.76/300ml.[14] Equivalent to 13p per 20mg dose (10ml).	Assuming a 50% reduction in prescribing **£2.7 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
12. Lidocaine plasters/ patches	NICE does not include lidocaine in their recommendations for neuropathic pain due to the limited clinical evidence supporting their use.[28] The Scottish Medicines Consortium (SMC) advised that lidocaine patches are accepted for restricted use for the treatment of post-herpetic neuralgia (PHN) in patients who are intolerant of first-line systemic therapies or where they are ineffective.[29]	Prescribe to patients who have been treated in line with NICE guidance on chronic pain [NG193] but are still experiencing neuropathic pain associated with previous herpes zoster infection (PHN). Prescribe only if the decision has been made after a multidisciplinary team discussion. Lidocaine plasters are not an alternative to an opioid-based medicine when concerned about dependence and withdrawal.[1]	Capsaicin 0.075% cream applied 3 to 4 times daily. £14.58/45g[14] Gabapentin 3600mg daily in three divided doses:[14] 100mg: £1.97/100 capsules 300mg: £2.27/100 capsules 400mg: £3.05/100 capsules 600mg: £9.92/100 tablets 800mg: £26.91/100 tablets (note the tablets are higher cost)	Assuming a 50% reduction in prescribing **£15.4 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
13. Liothyronine (including Armour Thyroid and liothyronine combination products)	There is a lack of strong evidence and liothyronine is significantly more expensive than levothyroxine.[1] Do not prescribe thyroid extracts (e.g., Armour thyroid, ERFA Thyroid), compounded thyroid hormones, iodine-containing preparations and dietary supplementation for primary hypothyroidism on the NHS as the safety, quality and efficacy of these products cannot be assured.[30]	Only if no other item is available or clinically appropriate, and only if initiated by, or considered appropriate following a review by an NHS consultant endocrinologist/psychiatrist (for overt hypothyroidism/ depression).[30] Prescriptions for individuals already receiving liothyronine should continue until that review has taken place.[30] This recommendation does not apply to patients who have already been reviewed by an NHS consultant endocrinologist/psychiatrist.[30] Where liothyronine is prescribed for the treatment of depression in patients with suspected or established thyroid disease, this should be under the advice of both an NHS consultant psychiatrist and NHS consultant endocrinologist.[30] Prescribing should only be transferred to primary care after a successful three month trial. This should be under a shared care agreement if for depression (off-label use).[15,30] Shared care may be appropriate, if agreed by local commissioners, for any ongoing prescribing of liothyronine in primary care. Liothyronine for patients with thyroid cancer, in preparation for radioiodine ablation, iodine scanning or stimulated thyroglobulin test should not be prescribed in primary care.	Levothyroxine monotherapy:[14] 12.5mcg: £14.64/28 tablets (note higher cost) 25mcg: £0.77/28 tablets 50mcg: £0.68/28 tablets 75mcg £3.02/28 tablets 100mcg: £0.69/28 tablets After a review, if the decision is to withdraw liothyronine prescribed as monotherapy or in combination with levothyroxine, withdrawal should be gradual in line with NHS consultant endocrinologist recommendations and may take many months to complete.[30]	Assuming a 50% reduction in prescribing **£5.8 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
14. Lutein and antioxidant vitamins	The evidence base does not show that lutein and other eye vitamin supplements are beneficial.[1]	None foreseen.	Advise to purchase over-the-counter if still desired after understanding that that there is a lack of evidence of efficacy.	Assuming a 100% reduction in prescribing **£324,437**
15. Minocycline for acne	Minocycline has various safety risks associated with its use, such as drug induced lupus erythematosus, pigmentation and hepatitis.[31] There are alternative tetracyclines (lymecycline or doxycycline) which can be taken once daily to aid compliance, with a lower risk of side effects.[31]	None foreseen.	Lymecycline 408mg daily. £4.03/28 capsules.[14] Doxycycline 100mg daily. £1.04/8 capsules.[14]	Assuming a 90% reduction in prescribing **£208,085**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
16. Needles for pre-filled and reusable insulin pens	Safer sharps are medical sharps that incorporate features or mechanisms to prevent or minimise the risk of accidental injury.[32] As they are intended to prevent injury to health and social care professionals from recapping of needles, they should not be prescribed on the NHS. It is the responsibility of the health or social care worker's employer to provide these in appropriate situations.[32] Patients self-administering their insulin should be switched to a cost-effective alternative as risk of needle-stick injury is reduced.	Exceptional circumstances only, i.e. for use by people who are not employees in the health and social care sectors but are administering insulin to a patient where there is a risk of disease transmission, such as HIV or hepatitis. A risk assessment may be useful.	Supplied by the health or social care worker's employer. For self-administration, switch to the most cost-effective 4mm needle, where appropriate, with appropriate advice on the correct injection technique.[33] Cost should not exceed >£5 per 100 needles.	Assuming a 90% reduction in prescribing **£7.5 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
17. Omega-3 fatty acid compounds (excluding icosapent ethyl [Vazkepa®])	Not recommended for the secondary prevention of myocardial infarction by NICE, who state: "Do not offer or advise people to use omega-3 fatty acid capsules or omega-3 fatty acid supplemented foods to prevent another MI".[34] However, the SMC advise that it is "acceptable for general use within NHS Scotland as an additional treatment for the secondary prevention of myocardial infarction".[35] NICE states do not use/offer/take omega 3 fatty acids: • to manage sleep problems in autistic children and young people.[36] • for the prevention of CVD (excluding icosapent ethyl) either alone or in combination with a statin.[37] There is no evidence that omega-3 fatty acid compounds help to prevent CVD.[37] • or omega-6 fatty acid compounds to treat MS. There is no evidence that they affect relapse frequency or progression of MS.[38] • to adults with non-alcoholic fatty liver disease (NAFLD) because there is not enough evidence to recommend their use.[39] • to people with familial hypercholesterolaemia.[40] NICE also states: • that the randomised controlled trial evidence for using omega-3 fatty acid medicines off-label in people with schizophrenia is limited and the results are not consistent.[41] The SMC states that omega-3-acid ethyl esters are not recommended for use in Scotland for hypertriglyceridaemia.[42]	None foreseen	Advise to purchase over-the-counter if still desired after explaining there is a lack of robust evidence of clinical effectiveness or significant safety concerns.[1]	Assuming a 90% reduction in prescribing **£2.5 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
18. Oxycodone/ naloxone combination products	Naloxone is included with the aim of counteracting opioid-induced constipation by blocking the action of oxycodone at opioid receptors locally in the gut.[43] The benefit of using an oxycodone/ naloxone combination product in patients receiving regular laxatives is uncertain.[44] Furthermore, there is no evidence that it reduces the need for additional laxatives. Oxycodone/naloxone prolonged release tablets (Targinact®) are not recommended for use within NHS Scotland for the treatment of severe pain which can be adequately managed only with opioid analgesics.[44]	Prescribe only if the decision to prescribe has been made after a multidisciplinary team discussion. Prescribe the most cost-effective preparation.	Oral morphine modified-release plus senna or lactulose.	Assuming an 80% reduction in prescribing **£1.4 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
19. Paracetamol/ tramadol combination products	The fixed dose combination of 37.5mg tramadol plus 325mg paracetamol per tablet contains sub-therapeutic doses of paracetamol and tramadol and inhibits the appropriate titration of each drug.[45] Tramadol 37.5mg/paracetamol 325mg tablet (Tramacet®) is not recommended for use within NHS Scotland for the symptomatic treatment of moderate to severe pain.[46] In addition, tramadol was mentioned in 12% of drug misuse deaths in England and Wales in 2013 (as the third most common opioid behind heroin/morphine and methadone).[47]	None foreseen.	Paracetamol at a therapeutic dose, plus the addition of suitable opioid analgesia, as appropriate.	Assuming a 90% reduction in prescribing **£355,596**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
20. Perindopril arginine	Perindopril arginine (Coversyl® Arginine) has no clinical benefit over the generic perindopril erbumine salt and can be more costly.[48] Any branded prescriptions that does not specify whether the arginine or erbumine salt is intended, results in branded Coversyl® Arginine being dispensed.[48]	None foreseen.	Generic perindopril erbumine is preferred. For patients receiving Coversyl® Arginine Plus (perindopril and indapamide combination product), there is no direct switch. However, prescribing perindopril erbumine alongside an appropriate diuretic as a separate component or a perindopril erbumine/amlodipine combination treatment is the best option. Separate components allow greater flexibility of dosing.	Assuming a 90% reduction in prescribing **£628,404**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
21. Rubefacients, benzydamine, mucopolysaccharide and cooling products (excluding topical NSAIDs and capsaicin)	Rubefacients and miscellaneous topical analgesics (benzydamine, mucopolysaccharide polysulphate and cooling gels/sprays) lack a robust clinical evidence base to support their use.[49] The National Institute for Health and Care Excellence (NICE) did not make a recommendation for research on rubefacients because they did not think that these would benefit people with osteoarthritis.[20]	None foreseen. Please note: The PrescQIPP bulletin recommendations do not apply to the prescribing of rubefacients for relieving muscle pain associated with methadone withdrawal.[49]	Advise to purchase over-the-counter if still desired after explaining there is a lack of robust evidence of clinical effectiveness or significant safety concerns. Do not automatically substitute with topical NSAID preparations.[48]	Assuming an 80% reduction in prescribing **£1.5 million**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
22. Silk garments	The evidence relating to the use of silk garments for eczema and atopic dermatitis is weak and of low quality.[50] They are also costly.[14] A trial in 300 children concluded that the addition of silk garments to standard atopic eczema care is unlikely to improve severity, or to be cost-effective compared with standard care alone, for children with moderate or severe atopic eczema.[51] There was no difference between the two groups in number of skin infections, or quality of life and wearing the silk clothing did not reduce the number of doctor visits for eczema or use of eczema medications.[51,52]	None foreseen.	Advise to purchase over-the-counter if still desired after explaining the lack of robust data demonstrating clinical effectiveness.	Assuming a 90% reduction in prescribing **£397,698**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
23. Travel vaccines	Vaccines for travel to high-risk areas are deemed a low priority for NHS funding.[1] These include:[53] • Hepatitis B • Japanese encephalitis • Meningitis vaccines • Rabies • Tick-borne encephalitis • Tuberculosis (TB) • Yellow fever As hepatitis B is not available on the NHS for travel, the combined hepatitis A and B vaccination should not be given for travel as travellers should be asked to pay for the hepatitis B component.	The following travel vaccines are available free of charge on the NHS as they protect against diseases thought to represent the greatest risk to public health if they were brought into the country:[53] • Polio (given as a combined diphtheria/ tetanus/polio vaccination) • Typhoid • Hepatitis A • Cholera	Patients should be charged privately for travel vaccines not available on the NHS.	Assuming a 90% reduction in prescribing **£360,516**

Item	Why is it considered to be a low priority for prescribing?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative Annual Saving (England, Scotland and Isle of Man)
24. Trimipramine	Trimipramine is a tricyclic antidepressant (TCA) that has been subject to significant price increases.[14] Consequently, it does not represent a cost-effective choice. The current cost per 28 days for trimipramine is currently £435 (based on a maintenance dose of 100mg daily).[14] SSRIs are recommended first-line as they have a more favourable risk-benefit ratio.[15]	If alternative antidepressants are unsuitable for the individual patient or the risk of uncontrolled symptoms of depression means a switch is unfavourable.	Imipramine currently costs £3.66 for 28 days (based on a maintenance dose of 75mg daily).[14] Where an SSRI would be more appropriate, sertraline 100mg currently costs £1.21 for 28 tablets (based on a maintenance dose of 100mg daily).[14]	Assuming a 90% reduction in prescribing **£5.7 million**

Additional information

NHS England. Items which should not routinely be prescribed in primary care: policy guidance. October 2023. https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/

NHS England. Shared Care Protocols (SCPs). Last updated December 2022. https://www.england.nhs.uk/publication/shared-care-protocols/

Summary

Reviewing products that represent a low priority for prescribing on the NHS because they are poor value for money, suitable for self-care or for which there are safer, more suitable alternatives is important to ensure high quality patient care and the best use of limited NHS resources.

References

1. NHS England. Items which should not routinely be prescribed in primary care: policy guidance. October 2023. https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/
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Additional PrescQIPP resources

Briefing	https://www.prescqipp.info/our-resources/bulletins/bulletin-339-low-priority-prescribing/
Implementation tools	

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