Cannock Chase Clinical Commissioning Group
East Staffordshire Clinical Commissioning Group
North Staffordshire Clinical Commissioning group
Stafford and Surrounds Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

NHS

PRESCRIBING POLICY ON DRUGS OF LIMITED CLINICAL VALUE

FINAL DRAFT

September 2019

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Responsible individual	
Author(s)	Samantha Buckingham
Date ratified by Governing Body	
Date issued	
Review date	3 years from issue date unless significant changes are required.
Target audience	All healthcare providers within and commissioned by: NHS Cannock Chase CCG NHS East Staffordshire CCG NHS North Staffordshire CCG NHS Stafford & Surrounds CCG NHS South East Staffordshire & Seisdon CCG NHS Stoke-on-Trent CCG

HISTORY OF CHANGES		
Old version number	**Significant changes**	**New version number**
2.0	• Update for Policy to cover all Staffordshire CCGs. • Name change from Prescribing Commissioning Policy to Prescribing Policy on Drugs of Limited Clinical Value. • Update following NHS England publication of guidance on items which should not routinely be prescribed in	3.0

	primary care.
	• Drugs included restricted to those included within NHS England Guidance.
	• Cough and cold remedies removed (included within self-care policy)
	• Capsaicin removed – now included within NICE guidance
	• Eflornithine removed
	• Cannabis removed
	• Dental products removed
	• Following items added/updated from NHS E guidance:
	    o Aliskiren
	    o Amiodarone
	    o Bath & shower preparations
	    o Dronedarone
	    o Minocycline
	    o Pen needles
	    o Rubifacients
	    o Silk garments	

1.0 INTRODUCTION

The purpose of this Commissioning Policy is to clarify the commissioning intentions for prescribing medications with limited clinical value in the Clinical Commissioning Groups of NHS Cannock Chase, NHS East Staffordshire, NHS North Staffordshire, NHS Stafford & Surrounds, NHS South East Staffs & Seisdon Peninsula and NHS Stoke-on-Trent.

NHS Commissioners receive funding to commission health services for their resident population and make decisions within the context of statutes, statutory instruments, regulations and guidance. NHS Commissioners have a responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them. It is necessary to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the population.

This Policy is designed to help the CCGs to meet their obligation in providing equitable access to health care. It aims to achieve this by ensuring prescribing locally is evidence-based and offers the NHS value for money.

2.0 AIMS & OBJECTIVES

The purpose of this document is to provide an organisation-wide process for the prescribing of Drugs of Limited Clinical Value. The reasons for this are to:

- Enable the CCG to meet financial responsibilities in ensuring the NHS offers value for money
- Provides a clear and robust process for the prescribing of Drugs of Limited Clinical Value
- To align the prescribing commissioning of the CCG is in accordance with national guidance from NHS England
- Ensure consistency in the prescribing of Drugs of Limited Clinical Value across all CCG commissioned services

3.0 SCOPE

The Policy covers all aspects of the prescribing of drugs of limited clinical value in all CCG commissioned services across Staffordshire.

The Policy is applicable to prescribing for all CCG patients within primary care and also within all CCG commissioned services.

4.0 DEFINITIONS

Abbreviations of terms used within this policy are given below:

CCG	Clinical Commissioning Group
NICE	National Institute for Clinical Excellence
NICE CG	NICE Clinical Guidance
NICE TAG	NICE Technology Appraisal
POM	Prescription only medication
ACBS	Advisory Committee on Borderline Substances
NHS E	NHS England
APC	Area Prescribing Committee (North Staffordshire)
APG	Area Prescribing Group (South Staffordshire)

6.0 ROLES AND RESPONSIBILITIES

An overview of the individual, departmental and committee duties, including levels of responsibility for document development.

Duties within the organisation:

- **Accountable Officer** – The Accountable Officer has overall responsibility for the strategic and operational management of each of the CCGs, including ensuring that the organisation's policies comply with all legal, statutory and good practice requirements.
- **Executive Team** – All Executive Directors are responsible for identifying and implementing policies relevant to their area of responsibility. Draft policies are to be reviewed by the Executive Directors as appropriate.
- **Governing Bodies** – The Governing Bodies are responsible for setting the strategic context in which organisational policies are developed and for the formal approval and ratification of policies. The Governing Bodies may delegate approval authority to a committee. The Governing Bodies will have copies of policies

available to Governing Body members at CCG Governing Body meetings in common.

- **Sub committees of the Governing Bodies** – Each Committee has delegated responsibility from the Governing Bodies for reviewing and approving new and appropriate revised policies. Policies are then passed to the Governing Bodies for formal approval and ratification.
- **Heads of Service/Managers** – Heads of Services/Managers have a responsibility to ensure that all staff have access to and are made aware of policies that apply to them. Heads of Service/Managers are responsible for reviewing the policies in their area and ensuring they remain relevant e.g. in line with any new guidance etc.

Addition roles and responsibilities:

CCG Area Prescribing Group (South Staffordshire) and Area Prescribing Committee (North Staffordshire)

- The APC and APG are responsible for the clinical approval and support of this Policy prior to ratification by the appropriate CCG boards.

GP and non-medical prescribers responsibilities:

- Prescribers should use this policy, together with clinical judgement, to support clinically-effective decision making for prescribing

7.0 POLICY REVIEW

The Policy will be reviewed every three years unless significant changes are required prior to this review date.

8.0 PRESCRIBING OF DRUGS OF LOW CLINICAL VALUE

This Policy defines the local commissioning position on the prescribing of Drugs with Limited Clinical Value. This is based on national guidance from NHS England on *Items Which Should Not Routinely Be Prescribed In Primary Care***.** Following a national consultation, NHS England published guidance on items which should not be routinely prescribed in primary care on 30th November 2017. This guidance is addressed to CCGs to support them to fulfil their duties around appropriate use of their resources. NHS E expect CCGs to take the proposed guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. These recommendations were incorporated into the previous version of this Policy within South Staffordshire.

NHS England further updated this guidance in June 2019 to include additional items within a second version of the document.[1] This update has been reflected in this Policy.

Medicines optimisation is key to achieving the best outcomes for patients. The Royal Pharmaceutical Society good practice guide on medicines optimisation suggests the following principles are key to help patients get the most out of their medicines.[2] These principles would apply when reviewing drugs in the DROP-List.

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

The drugs list within the policy is divided into 2 sections:

List A: Drugs not commissioned for prescribing within Staffordshire (Appendix 1)

These drugs are not suitable for prescribing locally due to recommendations from NHS England due to lack of clinical evidence. These drugs should not routinely be prescribed.

List B: Drugs which are only recommended for prescribing within Staffordshire in certain circumstances (Appendix 2)

These drugs should not routinely be prescribed unless clinically indicated for the individual patient in certain circumstances (as detailed in the appendix).

All CCG commissioned services should comply with the recommendations within this Policy on the prescribing of drugs with limited clinical value.

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Appendix 1: List A - Drugs not commissioned for prescribing within Staffordshire

These drugs are not suitable for prescribing locally due to recommendations from NHS England due to lack of clinical evidence. These drugs should not routinely be prescribed.

Drug or Treatment	Rationale for inclusion in the Policy	Suggested alternative(s)
Aliskiren (Rasilez®) **[New 2019]**	**Not commissioned for prescribing.** NICE state there is insufficient evidence of its effectiveness to determine its suitability for use in resistant hypertension.[3] NHS England Guidance for CCGs[1:] • Advise CCGs that prescribers in primary care should not initiate aliskiren for any new patient. • Advise CCGs to support prescribers in deprescribing aliskiren in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.**	For hypertension, a generic ACE inhibitor. For resistant hypertension, follow the NICE CG127.[3]
Bath and Shower preparations **[New 2019]**	**Not commissioned for prescribing.** A multicentre pragmatic parallel group RCT looking at emollient bath additives for the treatment of childhood eczema (BATHE) showed that there was no evidence of clinical benefit for including emollient bath additives in the standard management of childhood eczema. In the absence of other good quality evidence NHS E have accepted it is appropriate to extrapolate this to apply to use in adults.[1] NHS England Guidance for CCGs[1:] • Advise CCGs that prescribers in primary care should not	Soap avoidance and 'Leave-on' emollient moisturisers can still be used for treating eczema. These emollients can also be used as a soap substitute. Patients should be counselled on the use of any emollients as soap substitutes and the risk of using bath and shower emollients should be fully explained.

	initiate bath and shower preparations for any new patient. • Advise CCGs to support prescribers in deprescribing bath and shower preparations in this category and substitute with "leave-on" emollients and, where appropriate, to ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.**	
Complementary Therapies/ Herbal medications	There is a limited evidence base and a lack of robust randomised controlled trials directly comparing them with standard treatments. Some are also associated with severe adverse effects, they may significantly interact with other medicines and can delay accurate diagnosis of underlying pathology. None reviewed by NICE recommend their use. Many products are not prescribable on NHS prescriptions as set out in Part XVIIIA of the Drug Tariff. NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate herbal items or homeopathic medication for any new patient. • prescribers should be supported in deprescribing herbal items or homeopathic medication in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.**	Purchase as over-the-counter products.
Co-proxamol	**Not commissioned for prescribing.** Markedly more toxic in overdose than paracetamol. Withdrawn from	Alternative analgesics e.g. paracetamol and codeine or co-codamol tablets.

<table>
<tr><td></td><td>the market in 2005 due to safety concerns and marketing authorisations cancelled at end of 2007.[4]

NHS England Guidance for CCGs[1]:
• prescribers in primary care should not initiate co-proxamol for any new patient.
• prescribers should be supported in deprescribing co-proxamol in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

No routine exceptions have been identified.</td><td></td></tr>
<tr><td>Doxazosin Modified-Release (MR)</td><td>Not commissioned for prescribing.

No good evidence of additional benefit over immediate release doxazosin. Both formulations provide effective blood pressure control (doxazosin is recommended only as a fourth-line antihypertensive) and are effective at controlling the symptoms of BPH and improving maximum urinary flow rate. The long half-life of immediate release doxazosin allows once daily dosing.

NHS England Guidance for CCGs[1]:
• prescribers in primary care should not initiate doxazosin MR for any new patient.
• prescribers should be supported in deprescribing doxazosin MR in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

No routine exceptions have been identified.</td><td>Doxazoxin immediate-release preparations.</td></tr>
<tr><td>Glucosamine/ Glucosamine &</td><td>Not commissioned for prescribing.</td><td>Glucosamine +/- chondroitin are available as over-the-counter products to patients to</td></tr>
</table>

Chondroitin	Do not do recommendation in NICE CG177.[5] *"Do not offer glucosamine or chondroitin products for the management of osteoarthritis."* *Reviewed by the South Staffordshire Clinical Prioritisation Group and not recommended for prescribing.* NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate glucosamine and chondroitin for any new patient. • prescribers should be supported in deprescribing glucosamine and chondroitin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.**	purchase.
Lutein and antioxidant vitamins for age-related macular degeneration	**Not commissioned for prescribing.** Evidence base does not show that lutein and other eye vitamins are beneficial for age-related macular degeneration.[6] Products are food supplements and not licenced medicines. NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate lutein and antioxidants for any new patient. • prescribers should be supported in deprescribing lutein and antioxidants in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.**	Lutein and antioxidant vitamins are available as over-the-counter products for patients to purchase.

Minocycline for acne	**Not commissioned for prescribing.** Not considered first line tetracycline for acne. Increased risk of side effects, including greater risk of lupus erythematosus-like syndrome and irreversible pigmentation. NICE CKS advises Minocycline is not recommended for use in acne as it is associated with an increased risk of adverse effects such as drug induced lupus, skin pigmentation and hepatitis. NHS England Guidance for CCGs[1]: • Advise CCGs that prescribers in primary care should not initiate minocycline for any new patient with acne. • Advise CCGs to support prescribers in deprescribing minocycline in all patients with acne and, where appropriate, ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.**	*Please refer to the local Primary Care Antimicrobial Prescribing Guidelines for further information.*
Omega-3 and other fish oils	**Not commissioned for prescribing.** • For secondary prevention of myocardial infarction NICE CG172 states: "*Do not offer or advise people use omega-3 fatty acid capsules or omega 3 fatty acid supplemented foods to prevent another MI." "Advise people to eat a Mediterranean-style diet (more bread, fruit, vegetables and fish; less meat; and replace butter and cheese with products based on plant oils)*".[7] • NICE CG170 states *"Do not use omega-3 fatty acids to manage*	NICE recommendation is that patients should eat a Mediterranean style diet (more bread, fruit, vegetables and fish; less meat; and replace butter and cheese with products based on plant oils). Omega-3 and other fish oils are available as over-the-counter products to patients to purchase.

	sleep problems in children and young people with autism".[8] • NICE do not recommend fish or algal oils solely with the aim of preventing hypertensive disorders in pregnancy[9] or omega-3 fatty acid supplements for familial hypercholesterolaemia.[10] NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate omega-3 Fatty Acids for any new patient. • prescribers should be supported in deprescribing omega-3 Fatty Acids in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.**	
Oxycodone/Naloxone (Targinact®)	**Not commissioned for prescribing.** Randomised controlled trials have only compared with standard-release oxycodone, NOT with other strong opioids such as morphine, together with regular laxatives. Naloxone element has no effect on risk of overdose as it is not absorbed – it just acts on the GI tract. There is also no data showing that combined oxycodone and naloxone reduce the need for laxatives in the long-term. NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate oxycodone and naloxone combination product for any new patient. • prescribers should be supported in deprescribing oxycodone and naloxone combination product in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.	Alternative opioid analgesics with regular laxatives.

<table>
<tr><td></td><td>if, in exceptional circumstances, there is a clinical need for oxycodone and naloxone combination product to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.
No routine exceptions have been identified.</td><td></td></tr>
<tr><td>Paracetamol/Tramadol (Tramacet®)</td><td>Not commissioned for prescribing.

Fixed dose combination of 37.5mg tramadol plus 325mg paracetamol per tablet. No more effective than established analgesics in acute or chronic pain,[11] contains a sub-therapeutic amount of paracetamol and is more expensive than alternatives.

There are safety concerns with tramadol (harms and misuse) as well as an increased number of deaths.[12]

NHS England Guidance for CCGs[1:]
prescribers in primary care should not initiate paracetamol and tramadol combination product for any new patient.
prescribers should be supported in deprescribing paracetamol and tramadol combination product in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
No routine exceptions have been identified.</td><td>Alternative formulary analgesics (paracetamol, codeine, co-codamol or tramadol).</td></tr>
<tr><td>Perindopril arginine (Coversyl® Arginine and
Coversyl® Arginine</td><td>Not commissioned for prescribing.

No benefit over generic perindopril erbumine and it is more costly.[13]</td><td>Perindopril erbumine.</td></tr>
</table>

Plus)	Coversyl® prescribed by brand name will be dispensed as Coversyl® arginine. NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate perindopril arginine for any new patient. • prescribers should be supported in deprescribing perindopril arginine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.**	
Rubefacients (excluding capsaicin and topical NSAIDs) **[Updated 2019]**	**Rubefacients (excluding capsaicin and topical NSAIDs) - not commissioned for prescribing.** Topical rubefacient preparations may contain nicotinate and salicylate compounds, essential oils, and camphor which are all irritants. There is no clinical evidence for improvement in symptoms. The BNF states there is a lack of evidence for the use of rubefacients in both acute and chronic pain. *NICE do not recommend the use of rubefacients for the management of osteoarthritis.*[5] NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate rubefacients (excluding topical NSAIDs and capsaicin) for any new patient. • prescribers should be supported in deprescribing rubefacients (excluding topical NSAIDs and capsaicin) in all	Rubefacients are available as over-the-counter products to patients to purchase or use alternative topical NSAID products if appropriate.

	patients and, where appropriate, ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.**	
Silk garments **[New 2019]**	**Not commissioned for prescribing.** NHS England Guidance for CCGs[1]: • Advise CCGs that prescribers in primary care should not initiate silk garments for any patient. • Advise CCGs to support prescribers in deprescribing silk garments in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. **No routine exceptions have been identified.** Due to limited evidence supporting the efficacy of silk clothing for the relief of eczema, the NIHR HTA programme commissioned the CLOTHES trial, which aimed to examine whether adding silk garments to standard eczema care could reduce eczema severity in children with moderate to severe eczema, compared to use of standard eczema treatment alone. Overall the trial concluded that using silk garments for the management of eczema is unlikely to be cost-effective for the NHS.	Alternative management of eczema or dermatitis.
Once daily tadalafil	**Not commissioned for prescribing.** NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate once daily tadalafil for any new patient. • prescribers should be supported in deprescribing once daily tadalafil in all patients and, where appropriate, ensure the	Alternative recommended treatments for erectile dysfunction or benign prostatic hyperplasia.

	availability of relevant services to facilitate this change. **No routine exceptions have been identified.** Tadalafil is a phosphodiesterase-5-inhibitor and is available in strengths of 2.5mg, 5mg, 10mg and 20mg used to treat erectile dysfunction. In addition 2.5mg and 5mg can be used to treat benign prostatic hyperplasia. Only 2.5mg and 5mg should be used once daily. 10mg and 20mg6 are used in a "when required fashion". Tadalafil can be prescribed for erectile dysfunction in circumstances as set out in part XVIIIB of the Drug Tariff. Benign Prostatic Hyperplasia: NICE terminated their technology appraisal (TA273) due to receiving no evidence from the manufacturer. In NICE CG97: Lower Urinary Tract Symptoms in Men.[14] NICE state that there is not enough evidence to recommend phosphodiesterase inhibitors in routine clinical practice. Erectile Dysfunction: PrescQIPP CIC have reviewed the evidence for Tadalfil and although tadalafil is effective in treating erectile dysfunction, there is not enough evidence to routinely recommend once daily preparations in preference to "when required" preparations particularly as when required preparations are now available as a generic. Due to recommendations from NICE and that alternative tadalafil preparations are available, the joint clinical working group felt once daily tadalafil was suitable for inclusion in this guidance.	
Travel vaccine not prescribable on the	**Not commissioned for prescribing.**	Patients should be charged privately for all travel vaccines not prescribable on the

NHS	Hepatitis B, Japanese encephalitis, tick-borne encephalitis, meningococcal meningitis, rabies, tuberculosis and yellow fever are not available on the NHS for the purposes of travel.[15] Hepatitis B is not available free of charge on the NHS for travel. Therefore the combined hepatitis A and B vaccination should not routinely be given for travel as travellers should be asked to pay for the hepatitis B component. *The combined hepatitis A and B vaccine may however be an option for children under 3 years of age if clinically appropriate.* Vaccinations available on the NHS for travel are diphtheria, polio and tetanus (combined booster), typhoid, hepatitis A and cholera. This is because these diseases are thought to pose the greatest risk to public health if brought back into the UK. NHS England Guidance for CCGs[1:] • Advise CCGs that prescribers in primary care should not initiate the stated vaccines exclusively for the purposes of travel for any new patient.	NHS.
Trimipramine	**Not commissioned for prescribing.** NHS England Guidance for CCGs[1:] • prescribers in primary care should not initiate trimipramine for any new patient. • support prescribers in deprescribing trimpramine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. Trimipramine is a tricyclic antidepressant (TCA) however the price of trimipramine is significantly more expensive than other antidepressants.	Alternative treatments for depression as per NICE CG90: Depression in Adults.[22]

	NICE CG90: Depression in Adults [16] recommends selective serotonin reuptake inhibitor (SSRI) antidepressants first line if medicines are indicated as they have a more favourable risk:benefit ratio compared to TCA. However if a TCA is required there are more cost-effective TCAs than trimipramine available. Due to the significant cost associated with trimipramine and the availability of alternative treatments, the joint clinical working group considered trimipramine suitable for inclusion in this guidance.	

Appendix 2: List B - Drugs which are only recommended for prescribing in certain circumstances

The following drugs should not routinely be prescribed unless clinically indicated for the individual patient in certain circumstances (as detailed below).

Drug or Treatment	Rationale for inclusion in the Policy	Suggested alternative(s)
Amiodarone **[New 2019]**	NICE clinical guideline on Atrial Fibrillation (AF) CG 180 puts greater emphasis on rate rather than rhythm control and has clarified the place of amiodarone in the treatment pathway: NICE have issued the following "Do not do" recommendation: Do not offer amiodarone for long-term rate control. [17] Amiodarone is a treatment option: • for rhythm control in people with left ventricular impairment or heart failure • Pre (4 weeks) and post (up to 12 months) electrical cardioversion • Pharmacological cardioversion in new onset AF • People undergoing cardiothoracic surgery to reduce risk of post-op AF NHS England Guidance for CCGs[1:] • Advise CCGs that prescribers should not initiate amiodarone in primary care for any new patient. • Advise CCGs that if, in exceptional circumstances, there is a clinical need for amiodarone to be prescribed, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional. Must be initiated by a specialist and only continued under a shared care arrangement for patients where other treatments cannot be used, have failed or is in line with NICE Guidance CG180. It may	Refer to NICE Guidance CG180[17]

	also be suitable in patients prior and post cardioversion or in specific patients who also have heart failure or left ventricular impairment.	
Dosulepin	**Not commissioned for prescribing for new patients - prescribing only appropriate for existing patients. Patients should be reviewed for alternative treatments when appropriate.** NICE CG90 for depression in adults states: "Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose."[16] NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate dosulepin for any new patient. • prescribers should be supported in deprescribing dosulepin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. • if, in exceptional circumstances, there is a clinical need for dosulepin to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.	Selective Serotonin Receptor Inhibitors (SSRIs) are first-line. Where non-SSRI antidepressants are required, prescribers should follow the NICE CG90.[22]
Dronedarone **[New 2019]**	NICE clinical guideline on Atrial Fibrillation (AF) CG 180 puts greater emphasis on rate rather than rhythm control and has clarified the place of dronedarone in the treatment pathway.[17] NHS England Guidance for CCGs[1]: • Advise CCGs that prescribers should not initiate dronedarone in primary care for any new patient. • Advise CCGs that if, in exceptional circumstances, there is a	Refer to NICE Guidance CG180[17]

	clinical need for dronedarone to be prescribed, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional. Must be initiated by a specialist and only continued under a shared care arrangement for patients where other treatments cannot be used, have failed or is in line with NICE Guidance CG180.	
Fentanyl immediate release formulations	NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate immediate release fentanyl for any new patient. • prescribers should be supported in deprescribing immediate release fentanyl in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. • if, in exceptional circumstances, there is a clinical need for immediate release fentanyl to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional. **These recommendations do not apply to patients undergoing palliative care treatment and where the recommendation to use immediate release fentanyl in line with NICE guidance has been made by a multi-disciplinary team and/or other healthcare professional with a recognised specialism in palliative care.** Morphine is the most valuable opioid for severe pain. Fentanyl is significantly more expensive and there are potential safety problems presented by these products, which provide relatively high doses of a potent opioid and are associated with complicated titration and maintenance instructions.[18]	Alternative formulary immediate-release opioids.
Lidocaine plasters	**Not commissioned for prescribing.**	Alternatives as per NICE Clinical

	NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate lidocaine plasters for any new patient (apart from exceptions below) • support prescribers in deprescribing lidocaine plasters in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. • if, in exceptional circumstances, there is a clinical need for lidocaine plasters to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional. NICE CG173 on neuropathic pain does not recommend the use of lidocaine patches as a treatment option due to limited clinical evidence supporting its use.[19] *Exceptions and further recommendations* These recommendations do not apply to patients who have been treated in line with NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings but are still experiencing neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia).	Guideline 173: Neuropathic Pain[12]
Liothyronine **(including Armour Thyroid and liothyronine combination products)**	**Only to be prescribed for clinically appropriate patients after specialist initiation when levothyroxine not clinically effective.** NHS England Guidance for CCGs[1]: • prescribers in primary care should not initiate liothyronine for any new patient • individuals currently prescribed liothyronine should be reviewed by a consultant NHS endocrinologist with consideration given to switching to levothyroxine where clinically appropriate	Levothyroxine.

	• a local decision, involving the Area Prescribing Committee (or equivalent) informed by National guidance (e.g. from NICE or the Regional Medicines Optimisation Committee), should be made regarding arrangements for on-going prescribing of liothyronine. This should be for individuals who, in exceptional circumstances, have an on-going need for liothyronine as confirmed by a consultant NHS endocrinologist. There is no robust clinical evidence on the use of liothyronine either alone or in combination with levothyroxine and it is not licensed for long-term use. There are some patients who can only achieve thyroid control with liothyronine however these patients need to have been clinically assessed by a specialist. The British Thyroid Association (BTA) has considered the evidence around L-T3 therapy, both alone and in combination with L-T4. The BTA advise that some patients, who have unambiguously not benefited from L-T4, may benefit from a trial of L-T4/L-T3 combination therapy. These patients should be supervised by accredited endocrinologists with documentation of agreement after being fully informed and have understood discussion of the uncertain benefits of treatment, likely risks of over-replacements, potential adverse consequences and lack of safety data.[20] The BTA do not recommend the use of L-T3 (liothyronine) therapy alone as there are no longer-term controlled clinical trials available which provide evidence to support this treatment. *Exceptions and further recommendations*	

	The British Thyroid Association (BTA) advise that a small proportion of patients treated with levothyroxine continue to suffer with symptoms despite adequate biochemical correction. In these circumstances, where levothyroxine has failed and in line with BTA guidance, endocrinologists providing NHS services may recommend liothyronine for individual patients after a carefully audited trial of at least 3 months duration of liothyronine. Liothyronine is used for patients with thyroid cancer, in preparation for radioiodine ablation, iodine scanning, or stimulated thyroglobulin test. In these situations it is appropriate for patients to obtain their prescriptions from the centre undertaking the treatment and not be routinely obtained from primary care prescribers.	
Needles for Pre-filled and Reusable Insulin Pens **[New 2019]**	NHS England Guidance for CCGs[1]: • Advise CCGs that prescribers in primary care should not initiate insulin pen needles that cost >£5 per 100 needles for any diabetes patient. • Advise CCGs to support prescribers in deprescribing insulin pen needles that cost >£5 per 100 needles and, where appropriate ensure the availability of relevant services to facilitate this change. Rationalising use ensures that the most cost-effective options are used first line. The Forum for Injection Technique (FIT) UK considers the 4mm needle to be the safest pen needle for adults and children regardless of age, gender and Body Mass Index (BMI). Using needles of a shorter length helps to prevent intramuscular injection of insulin. (IM injection of insulin should be avoided as it can result in unpredictable blood glucose levels). Therefore, needle choice should be the most cost effective 4mm needle. For patients currently using longer pen needle lengths (8mm, 12mm), it is	Review existing pen needle product prescribed.

	advisable to change to a shorter needle length (6mm or less) but only after discussion with a healthcare professional, to ensure they receive advice on the correct injection technique. For patients that are not able to self-administer it may be appropriate that a safety needle is used by the health care professional, however this would not need to be prescribed on prescription.	