NORTH EAST LONDON INTEGRATED CARE BOARD (NEL ICB)

POSITION STATEMENT

Following the publication of NHSE policy guidance on items which should not be routinely prescribed in primary care, the following changes have been agreed across NEL ICB:

1. **NEL does not support the routine prescribing of the following items and NO exceptions apply:**
   - Co-proxamol
   - Glucosamine and chondroitin
   - Herbal treatments and other natural products
   - Homeopathy
   - Lutein and antioxidants*
   - Minocycline for acne
   - Paracetamol and tramadol combination products*
   - Perindopril arginine*
   - Rubefacients (excluding topical NSAIDs)*
   - Silk garments

   *Due to the current lack of robust clinical evidence, NEL ICB has adopted a position of *no exceptions*. This approach differs from the broader stance outlined in the NHSE guidance.

The recommendations for these items are:

- Do **not** initiate in primary care
- Deprescribe or switch in patients currently prescribed this item

2. **NEL does not support the routine prescribing of the following items, however SOME exceptions apply:**
   - Aliskiren
   - Amiodarone*
   - Bath and shower preparations for dry and pruritic skin conditions
   - Co-enzyme Q10 (ubiquinone/ubidecarenone)
   - Dosulepin±
   - Doxazosin prolonged-release or modified-release
   - Dronedarone*
   - Fentanyl immediate release±
   - Lidocaine plasters±
   - Liothyronine
   - Needles £4.50 or more per 100
   - Omega-3 fatty acid compounds (excluding icosapent ethyl [Vazkepa®])
   - Oxycodone and naloxone combination product ±
   - Perindopril arginine plus indapamide combination
   - Travel vaccines*
   - Trimipramine

* Prescribing limited to named indications in the NHSE guidance

± Prescribing should only occur following a multidisciplinary team decision

The recommendations for these items are:

- Do **not** initiate in primary care, **unless** the patient meets the defined exception criteria
- Deprescribe in patients currently prescribed this item **unless** the patient meets the defined exception criteria
- Prescribe only if no other item or intervention is clinically appropriate
- Prescribe only if no other item or intervention is available
- Prescribe only if the item is for an indication named in this guidance

Table 1: Items which should not routinely be prescribed in primary care across NEL – no exceptions

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Co-proxamol (Paracetamol 325mg + Dextropropoxyphene 32.5mg)	Mild to moderate pain	**Not approved for prescribing**	Co-proxamol was withdrawn from the UK market by the Medicines and Healthcare products Regulatory Agency (MHRA) in 2007 due to significant safety concerns, particularly its increased toxicity in overdose compared to paracetamol alone. It is **no** longer manufactured in the UK and unlicensed prescribing requires it to be imported for individual use. In 2014, the MHRA reported that dextropropoxyphene can have serious effects on the electrical activity of the heart (resulting in prolongation of the P-R and Q-T intervals, and widened QRS complexes), even at normal therapeutic doses.	**Existing patients** – review and deprescribe. Review all patients prescribed co-proxamol for suitability for switching to paracetamol alone or paracetamol with codeine. As with all switches, these should be tailored to the individual clinical need of the patient. Alternatively, consult with the pain team and deprescribe where possible. Please note the NICE guideline for chronic pain NG193 recommends opioids, including tramadol and paracetamol, are **not** initiated for chronic primary pain. **New patients** – do **not** initiate co-proxamol.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Glucosamine and chondroitin	Relief of pain and symptoms associated with osteoarthritis	**Not approved for prescribing**	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. NICE guideline for osteoarthritis NG226 states do **not** offer glucosamine to manage osteoarthritis.	**Existing patients** – deprescribe. Patients should purchase these products over the counter (OTC) if they wish to continue treatment. Where the product is classified as a prescription only medicine (POM), patients will need to obtain it on a private prescription. **New patients** – do **not** initiate glucosamine and/or chondroitin.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Herbal treatments and other natural products	Various	**Not approved for prescribing**	Under a traditional herbal registration (THR), products do not need scientific proof of effectiveness; registration relies on their long-standing traditional use. These items should **not** be prescribed on the NHS because there is lack of scientific evidence of their clinical effectiveness, including the following: • Natural oils, e.g. eucalyptus oil • Coenzyme Q10 (ubiquinone and ubidecarenone) - *see table 2 for prescribing in cystic fibrosis and metabolic disorders* • Evening primrose (gamolenic acid) **Patient resource:** information leaflet – see Appendix A	**Existing patients** – deprescribe. Patients should purchase these products over the counter (OTC) if they wish to continue treatment. **New patients** – do **not** initiate herbal treatments or other natural products.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Homeopathy	Various	**Not approved for prescribing**	Homeopathy aims 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 prescribing of homeopathy on the NHS.	**Existing patients** – deprescribe. Patients should purchase these products over the counter (OTC) if they wish to continue treatment.
				New patients – do **not** initiate homeopathy.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Lutein and antioxidants	Age-related macular degeneration (AMD)	**Not approved for prescribing**	The evidence base does **not** show that lutein and other eye vitamin supplements are beneficial.	**Existing patients** – deprescribe. Patients should purchase these products over the counter (OTC) if they wish to continue treatment.
				New patients – do **not** initiate lutein and antioxidants.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Minocycline	Acne vulgaris	**Not approved for prescribing**	Minocycline is **not** recommended for acne due to an increased risk of adverse effects, including drug-induced lupus, skin pigmentation and hepatitis. Once daily tetracyclines with safer profiles e.g. doxycycline or lymecycline are preferred over minocycline to improve adherence. Where minocycline is initiated by a dermatologist for the treatment of acne vulgaris, prescribing should remain within secondary care.	**Existing patients** – review and deprescribe. For patients on minocycline where treatment for acne is still indicated, review treatment in line with NICE guideline for acne vulgaris NG198. Where minocycline has been initiated by a dermatologist for the treatment of acne vulgaris, secondary care should be consulted before any changes to treatment are made. **New patients** – do **not** initiate minocycline for acne vulgaris.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Paracetamol and tramadol combination products (Paracetamol 325mg + Tramadol 37.5mg)	Moderate to severe pain	**Not approved for prescribing**	Paracetamol 325mg and tramadol 37.5mg combination contains sub-therapeutic doses of both ingredients. There have been an increased number of reports of misuse and harms associated with tramadol, which have resulted in an increase in the number of tramadol related deaths. There is **no** evidence paracetamol and tramadol combination is more effective or safer than paracetamol 500mg and codeine 30mg (either individually or combined as co-codamol 30/500).	**Existing patients** – review and deprescribe. Review patients on paracetamol and tramadol combination for suitability for switching to paracetamol alone or paracetamol with codeine. As with all switches, these should be tailored to the individual clinical need of the patient. Please note NICE guideline for chronic pain NG193 recommends that opioids, including tramadol and paracetamol, are **not** initiated for chronic primary pain. **New patients** – do **not** initiate paracetamol and tramadol combination products.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Perindopril arginine	Hypertension Heart failure Prophylaxis of cardiac events	**Not approved for prescribing**	Perindopril arginine (Coversyl® arginine) has **no** clinical benefit over the generic perindopril erbumine salt and is more costly.	**Existing patients** – review. If perindopril arginine is indicated, review and switch to recommended perindopril erbumine salt at equivalent doses: • Perindopril arginine 2.5mg = perindopril erbumine 2mg • Perindopril arginine 5mg = perindopril erbumine 4mg • Perindopril arginine 10mg = perindopril erbumine 8mg As with all switches, these should be tailored to the individual clinical need of the patient. **New patients** – do **not** initiate perindopril arginine.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Rubefacients (excluding topical NSAIDs and capsaicin)	Soft-tissue disorders and topical pain relief	**Not approved for prescribing**	The evidence available does **not** support the prescribing of topical rubefacients in acute or chronic musculoskeletal pain. NICE guideline for osteoarthritis NG226 does **not** recommend rubefacients for treating osteoarthritis. **Patient resource:** information leaflet – see Appendix A	**Existing patients** – review and deprescribe. Reviewing rubefacient use allows reassessment of symptoms and management. Consider alternatives such as topical NSAIDs if appropriate but avoid automatic substitution. Patients should purchase these products over the counter (OTC) if they wish to continue treatment. **New patients** – do **not** initiate rubefacients (excluding topical NSAIDs).

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Silk garments	Relief of symptoms of eczema or dermatitis	**Not approved for prescribing**	The National Institute for Health and Care research commissioned the CLOTHES trial to look at whether silk garments had a role in reducing eczema severity in children. This concluded that silk garments are unlikely to be cost effective to the NHS.	**Existing patients** – deprescribe. Patients should purchase these products over the counter (OTC) if they wish to continue treatment after explaining the lack of robust data demonstrating clinical effectiveness.
				New patients – do **not** initiate silk garments.

Table 2: Items which should not routinely be prescribed in primary care across NEL – some exceptions apply

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Aliskiren	Hypertension	Prescribing may be appropriate in some **exceptional circumstances**	Aliskiren was discontinued in the UK in January 2025. According to the British National Formulary (BNF), **no** licensed aliskiren products were available in the UK at the time of publication of this document.	**Existing patients** – review and deprescribe if appropriate. Review and deprescribe where clinically appropriate to do so e.g. change to an alternative hypertensive agent in line with NICE guideline for hypertension NG136. If a patient is under the care of a hospital specialist, please obtain advice and guidance before deprescribing or switching.
				New patients – do **not** initiate aliskiren.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Amiodarone	Arrhythmias	Prescribing may be appropriate in some **specified indications**	Amiodarone has an important place in the treatment of severe cardiac rhythm disorders, however it has potential serious toxicity, and its use requires monitoring both clinically and via laboratory testing. Amiodarone **must** be initiated by a specialist. NICE guideline for atrial fibrillation NG196 puts greater emphasis on rate rather than rhythm control and clarifies the place of amiodarone in the treatment pathway.	**Existing patients** – review to ensure prescribing is still indicated and appropriate (liaise with the specialist if necessary). Monitor in accordance with the SPS guidance here. **Prescribe only for the following indications:** • Prior and post cardioversion for up to 12 months • In heart failure or left ventricular impairment • In-line with any other indication specified in the NICE NG196 guideline • To prevent life threatening arrhythmias such as ventricular tachycardia (VT) or ventricular fibrillation (VF)
				New patients – do **not** initiate amiodarone. May be prescribed in primary care as outlined above for certain indications following specialist initiation. Ensure that monitoring is undertaken as per SPS guidance here.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Bath and shower preparations	Dry and pruritic skin conditions	Prescribing may be appropriate in some **exceptional circumstances**	Bath and shower preparations (emollient bath additives) are **not** recommended because they are not clinically or cost-effective. Bath emollient products are non-formulary and the NHS NEL emollient prescribing guidelines for primary care recommend that bath and shower preparations are **not** to be prescribed for mild dry skin conditions in children or adults If recommended by a secondary care dermatologist for severe eczema, prescribe as an acute medication and review at least every three months. **Patient resource:** information leaflet – see Appendix A	**Existing patients** – review and deprescribe if appropriate. Review and discontinue all prescribing of emollient bath additive and shower preparations. For diagnosed dry skin conditions, advise using leave-on emollients instead of soap (risk of falls associated with bath emollients). See NHS NEL emollient prescribing guidelines for primary care for further information. Patients should purchase these products over the counter (OTC) if they wish to continue treatment **New patients** – do **not** initiate bath and shower preparations.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Co-enzyme Q10 (ubiquinone/ ubidecarenone)	Various	Prescribing may be appropriate in some **specified indications**	Co-enzyme Q10 should **not** be prescribed on the NHS because there is lack of scientific evidence of its clinical effectiveness and is unlicensed. DEKAs Plus, which contains co-enzyme Q10, may be prescribed for use in cystic fibrosis (CF) if recommended by a CF specialist. Co-enzyme Q10 (ubiquinone or ubidecarenone) may be prescribed for metabolic disorders if recommended by an appropriate specialist.	**Existing patients** – review and deprescribe if appropriate. **New patients**: Do **not** initiate DEKAs Plus unless advised by a CF specialist for patients with CF. Do **not** initiate co-enzyme Q10 (ubiquinone or ubidecarenone) unless it is for a metabolic disorder and has been recommended by an appropriate specialist.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Dosulepin (formerly known as dothiepin)	Depression	Prescribing may be appropriate in some **exceptional circumstances**	Dosulepin is a tricyclic antidepressant (TCA) and evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose. Dosulepin should **not** be prescribed for unlicensed indications including anxiety, neuropathic pain or insomnia. **Patient resource:** information leaflet – see Appendix A	**Existing patients** **If initiated in primary care:** Refer to the dosulepin PrescQIPP bulletin (login required), SPS deprescribing guidance and SPS switching guidance to support a structured medication review. Where clinically appropriate, consider safely discontinuing or switching to an alternative or seek specialist advice. If in exceptional circumstances, where there is a clinical need for dosulepin to be prescribed in primary care, this should be undertaken in consultation following a multi-disciplinary team meeting or after discussion with another healthcare professional. **If initiated in secondary care:** Review and if necessary, liaise with the specialist team, discussing options including safely discontinuing or switching to a safer alternative antidepressant. See SPS deprescribing guidance and SPS switching guidance. **New patients** – do **not** initiate dosulepin in any patient.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Doxazosin prolonged release (also commonly known as doxazosin modified-release or XL)	Hypertension Benign prostatic hyperplasia (BPH)	Prescribing may be appropriate in some **exceptional circumstances**	There is **no** good evidence of additional benefit of doxazosin prolonged release over immediate release (also known as standard tablets). Both formulations provide effective blood pressure control and are effective at controlling the symptoms of benign prostatic hyperplasia (BPH). The long half-life of immediate release doxazosin allows once daily dosing. At the time of publication of this document, 8mg prolonged release tablets were considerably less expensive than 8mg immediate release tablets. However, 4mg immediate release tablets remain the preferred cost-effective option across NEL ICB NHS Electronic Drug Tariff. **Patient resource:** information leaflet – see Appendix A	**Existing patients** – review. Ensure that prescribing of doxazosin for hypertension is in line with NICE guideline NG136. Ensure that prescribing of doxazosin for BPH is in line with NICE guideline CG97. **Review patients using the following as a guide:** SPS guidance on switching doxazosin XL tablets to doxazosin standard tablets If initiated by the clinical pharmacology team or team specialising in the treatment of complex hypertension do **not** switch to immediate release doxazosin. **New patients** – do **not** initiate doxazosin prolonged release in new patients, unless recommended by the clinical pharmacology team or team specialising in the treatment of complex hypertension.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Dronedarone	Atrial fibrillation	Prescribing may be appropriate in some **specified indications**	The use of dronedarone is restricted to the maintenance of sinus heart rhythm in 'persistent' or 'paroxysmal' atrial fibrillation after normal heart rhythm has been restored (cardioversion) and when alternative treatments are unsuitable. NICE guidance NG196 puts greater emphasis on rate rather than rhythm control and clarifies the place of dronedarone in the treatment pathway. See also NICE TA197. Dronedarone **must** be initiated by a specialist.	**Existing patients** – review to ensure prescribing is still indicated and appropriate (liaise with the specialist if necessary). Monitor in accordance with the SPS guidance link here. **Prescribe only for the following indication:** On the advice of a specialist, for the maintenance of sinus heart rhythm after cardioversion in patients with paroxysmal or persistent atrial fibrillation, when alternative treatments are unsuitable (see NICE TA197 for further information). **New patients** – do **not** initiate dronedarone. May be prescribed in primary care as outlined above for certain indications following specialist initiation. Ensure that monitoring is undertaken as per SPS guidance link here.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Fentanyl immediate release formulations	Breakthrough pain relief	Prescribing may be appropriate in some **exceptional circumstances**	Fentanyl immediate-release (IR) 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 and is **not** first-line choice according to NICE CG140. Fentanyl IR is also significantly more expensive than immediate-release morphine and can cause dependence or withdrawal. There are various dosage forms including tablets, lozenges, films and nasal spray. This recommendation excludes palliative care patients prescribed fentanyl IR as per NICE guidelines CG140 by a multidisciplinary team and/or a palliative care specialist. **Patient resource:** information leaflet – see Appendix A	**Existing patients** – review. **If initiated in primary care:** Refer to the Fentanyl IR PrescQIPP bulletin (login required) to support a structured medication review and consider switching to alternative pain relief or obtaining specialist input where clinically appropriate. **If initiated in secondary care:** The appropriateness of continuing treatment or switching to alternative pain relief should be discussed with the initiating specialist team. **New patients** – do **not** initiate fentanyl immediate release unless advised by the palliative care team.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Lidocaine plasters	Symptomatic relief of neuropathic pain (post-herpetic neuralgia, PHN) associated with previous herpes zoster infection in adults.	Prescribing may be appropriate in some **exceptional circumstances**	This is a **hospital-only medicine** in NEL. NICE guideline for neuropathic pain CG173 does **not** recommend lidocaine plasters for the treatment of neuropathic pain. Lidocaine plasters can be prescribed only for patients who are intolerant of first-line systemic therapies for post-herpetic neuralgia or where these therapies have been ineffective. Prescribe only if the decision has been made after a multidisciplinary team discussion. **Patient resource:** information leaflet – see Appendix A	**Existing patients** – review. **If initiated in primary care:** Review and either deprescribe or switch in line with NICE guideline for neuropathic pain CG173. **If initiated in secondary care:** The Pharmacy and Medicines Optimisation team and secondary care colleagues are currently reviewing this and will provide further advice in due course. In the meantime, please continue to prescribe unless there is a valid clinical reason not to. **New patients** – do **not** initiate lidocaine plasters.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Liothyronine	Hypothyroidism and/or depression	Prescribing may be appropriate in some **exceptional circumstances**	There are significant costs associated with liothyronine and there is limited evidence to support its prescribing in preference to levothyroxine. Liothyronine should only be prescribed in accordance with NHSE guidance when **no** other treatment is suitable or clinically appropriate following a review by an NHS consultant endocrinologist/ psychiatrist (for overt hypothyroidism/ depression). Where liothyronine is prescribed for the treatment of depression in patients with suspected or established thyroid disease, this should be under the advice of an NHS consultant psychiatrist and NHS consultant endocrinologist. These are 'off-label' or unlicensed uses. The justification from the specialist as to why alternative treatments are unsuitable should be fully documented. **Prescriber resource**: Use of liothyronine (T3) in hypothyroidism	**Existing patients** **If initiated in primary care/non-NHS provider:** Refer patient to an NHS consultant endocrinologist or psychiatrist (for overt hypothyroidism or depression respectively). Continue liothyronine until reviewed, then follow the consultant's advice to stop, withdraw or continue in line with NHSE. **If initiated and reviewed by an NHS consultant endocrinologist/psychiatrist (for overt hypothyroidism/ depression):** Continue prescribing if in line with NHSE guidance. Do **not** prescribe the 2.5microgram strength, which is a costly special, unless specifically required for dosing. **New patients** – do **not** initiate liothyronine unless: • Following a review by an **NHS** consultant endocrinologist/psychiatrist (for overt hypothyroidism/depression) • Under the advice of an NHS consultant psychiatrist and NHS consultant endocrinologist for the treatment of

			Patient resource: information leaflet – see Appendix A	depression in patients with suspected or established thyroid disease

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Needles for pre-filled and reusable insulin pens (> £4.50 per 100 needles)	Administration of insulin and some glucagon like peptide-1 (GLP-1) analogue	Prescribing may be appropriate in some **exceptional circumstances**	Pen needles are available in sizes from 4mm to 12mm and cost from £3.95 to £30.08 for 100 needles. The Forum for Injection Technique (FIT) UK considers 4mm needle to be the **safest** pen needle for adults and children, regardless of age, gender and body mass index (BMI). Using shorter length needles helps prevent intramuscular injection of insulin. Therefore, the most cost-effective 4mm needle should be chosen. **Patient resource:** information leaflet – see Appendix A	**Existing patients** – review and switch as per NEL guidelines. For patients currently using longer pen needle lengths (8mm, 12mm), changing to a cost-effective shorter length needle is advised, but only after discussion with a healthcare professional to ensure they receive advice on the correct injection technique. **New patients –** do **not** initiate needles costing > £4.50 per 100 needles.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Omega-3 fatty acid compounds (**excluding** icosapent ethyl [Vazkepa®] with statin therapy for reducing the risk of cardiovascular events in people with raised triglycerides)	Hyper-triglyceridaemia Adjunct medication for symptoms associated with chronic mental health conditions (unlicensed indication) or any other unlicensed condition.	Prescribing may be appropriate in some **exceptional circumstances**	NICE TA805 recommends only one omega-3 fatty acid compound and only in specific clinical circumstances – icosapent ethyl [Vazkepa®], and that all other omega-3 fatty acid compounds are **not** suitable for prescribing. **Hospital-only medicine in NEL** for the unlicensed indication of adjunctive medication for symptoms associated with chronic mental health conditions. **Patient resource:** information leaflet – see Appendix A	**Existing patients** – review and deprescribe where appropriate. **If initiated in secondary care lipid clinic for the treatment of severe hypertriglyceridaemia:** Review and continue in line with the most recent correspondence and/or contact the lipid clinic if further guidance is required. **If initiated in secondary care for symptoms associated with chronic mental health conditions:** Repatriate prescribing back to secondary care. **New patients** – do **not** initiate omega-3 fatty acid compounds unless recommended by the lipid clinic for the treatment of severe hypertriglyceridaemia.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Oxycodone and naloxone combination product	Severe pain	Prescribing may be appropriate in some **exceptional circumstances**	This is a **hospital-only medicine in NEL** unless prescribed as part of a palliative care package. The benefit of using an oxycodone and naloxone combination product in patients receiving regular laxatives is uncertain. Furthermore, there is **no** evidence that it reduces the need for additional laxatives. **Patient resource:** information leaflet – see Appendix A	**Existing patients** – review. **If initiated in primary care:** Refer to oxycodone and naloxone (Targinact®) PrescQIPP bulletin (login required) to support a structured medication review. Consider switching to an alternative where clinically appropriate and obtaining specialist input if needed. Exception to this is when recommended by the palliative care team as part of a palliative care package. **If initiated in secondary care:** The appropriateness of continuing treatment or switching to an alternative opioid must be discussed with the initiating specialist team. Prescribing should be repatriated back to the hospital trust unless recommended by the palliative care team.
				New patients – do **not** initiate oxycodone and naloxone combination product unless recommended by the palliative care team as part of a palliative care package.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Perindopril arginine 5mg + Indapamide 1.25mg (Coversyl® Arginine Plus)	Hypertension	Prescribing may be appropriate in some **exceptional circumstances**	Perindopril arginine has **no** clinical benefit over the generic perindopril erbumine salt and is more costly. Continue prescribing for existing patients who are established on the perindopril arginine and indapamide combination to support adherence and/or where blood pressure remains well controlled.	**Existing patients** – review. There is no direct switch as indapamide is not available as a 1.25mg tablet. However, prescribing perindopril erbumine 4mg plus an appropriate diuretic separately is a suitable option and provides greater flexibility in dosing. **Review and consider switching to:** Perindopril erbumine 4mg once daily and indapamide (2.5mg immediate release once daily **or** 1.5mg modified release once daily). As with all switches, these should be tailored to the individual clinical need of the patient. **New patients** – do **not** initiate perindopril arginine and indapamide combination.

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Travel vaccines	Immunisation against infectious diseases	Prescribing may be appropriate in some **exceptional circumstances**	The following vaccinations should **not** be prescribed on the NHS exclusively for the purposes of travel: • Hepatitis B • Japanese encephalitis • Meningitis ACWY • Yellow fever • Tick-borne encephalitis • Rabies • BCG These vaccines should continue to be recommended for travel, but the individual traveller will need to bear the cost of the vaccination (to be prescribed on private prescription if for travel). For all other indications, as outlined in Immunisation Against Infectious Disease – the Green Book – the vaccine remains free on the NHS.	Only the following vaccines may be administered on the NHS exclusively for the purposes of travel, if clinically appropriate: • Cholera • Diphtheria/tetanus/polio • Hepatitis A • Typhoid

Item Name	Main Indication(s)	NEL Position	Rationale	Recommendations for Primary Care
Trimipramine	Depression	Prescribing may be appropriate in some **exceptional circumstances**	Trimipramine is a tricyclic antidepressant (TCA) and is significantly more expensive than other antidepressants (and TCAs). NICE guideline for depression in adults NG22 recommends selective serotonin reuptake inhibitor (SSRI) antidepressants as first-line as they have a more favourable risk-to-benefit ratio compared to TCAs. However, if a TCA is required, more cost-effective TCAs than trimipramine are available. **Patient resource:** information leaflet – see Appendix A	**Existing patients** **If initiated in primary care:** Refer to the trimipramine PrescQIPP bulletin (login required) and SPS guidance to support a structured medication review. Where clinically appropriate, consider switching to an alternative or seek specialist advice. **If initiated in secondary care:** The appropriateness of continuing treatment or switching to an alternative antidepressant should be discussed with the initiating specialist team or equivalent. **New patients** – do **not** initiate trimipramine.

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1 BACKGROUND with SPECIFIC DETAILS

The NHSE policy guidance on items which should not be routinely prescribed in primary care gives recommendations for items which should not be prescribed in primary care because:

- There are significant safety concerns with the item
- There is a lack of robust evidence of clinical effectiveness for the item
- The item is clinically effective but more cost-effective interventions are available
- The item is clinically effective but deemed a low priority for NHS funding

Prescribers are advised that no new patients should be started on these items, that they should be deprescribed for current patients and that, where possible, suitable alternatives should be identified for patients. However, the guidance does identify some circumstances where it may be appropriate to prescribe some of the items. As prescribers are advised to consider suitable alternatives, implementation of this guidance will ensure patients are prescribed medicines that are safer and more clinically and cost effective.

To support practices, the Pharmacy and Medicines Optimisation Team has developed a set of EMIS searches designed to help identify relevant patients on items which should not be routinely prescribed in primary care.

2 SCOPE

This position statement applies to recommendations made in the North East London (NEL) Joint Formulary and is intended for use by individual prescribers, the Integrated Medicine and Prescribing Committee (IMOC), its subgroups, and key stakeholders across the NEL Integrated Care System. It supports the implementation of NHS England guidance on items that should not be routinely

prescribed in primary care, and aims to promote safe, clinically effective and cost-efficient prescribing across NEL.

This position statement does **not** apply to products or indications where prescribing is explicitly supported by NHS England or where specialist initiation and review is required. Exceptions are clearly outlined within the document and include specific items, which may be prescribed under defined clinical circumstances following specialist input.

3 ROLES AND ESPONSIBILITIES

- Healthcare professionals are expected to consider the guidance recommendations when exercising their clinical judgement.
- The recommendations do **not** override the individual responsibility of healthcare professionals to support their patients in agreeing the most appropriate treatment options for them through taking a shared decision-making approach.
- The NHS North East London Pharmacy and Medicines Optimisation Team is responsible for reviewing this document and ensure information within the position statement is accurate and up to date.
- Prescribers should follow the actions listed in this position statement to ensure best practice for safe and effective prescribing and to support best patient care.
- GPs, non-medical prescribers, pharmacists are to ensure best practice for safe and effective prescribing and to support best patient care.
- This position statement should be adhered to when reviewing proposals and making prescribing recommendations.

4 INTERNAL AND EXTERNAL REFERENCES

British National Formulary (BNF). (2025) *BNF*. Available at: **https://bnf.nice.org.uk/** (Accessed: 13 November 2025).

Fit4Diabetes. *Fit4Diabetes*. Available at: **https://fit4diabetes.com/** (Accessed: 1 December 2025).

National Institute for Health and Care Excellence (NICE). (2025) *NICE*. Available at: **https://www.nice.org.uk/** (Accessed: 1 December 2025).

NHS Business Services Authority (NHSBSA). (2025) *Drug Tariff*. Available at: https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff (Accessed: 1 December 2025).

NHS England. (2023) *Items which should not routinely be prescribed in primary care: Policy guidance*. Available at: https://www.england.nhs.uk/publication/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/ (Accessed: 1 December 2025).

NHS England. (2023) *Liothyronine: Advice for prescribers*. Available at: https://www.england.nhs.uk/long-read/liothyronine-advice-for-prescribers/ (Accessed: 1 December 2025).

North East London Joint Formulary. (2025) *North East London Joint Formulary*. Available at: https://www.nel-jointformulary.nhs.uk/ (Accessed: 1 December 2025).

PrescQIPP. (2024) *Bulletin 339: Low priority prescribing*. Available at: https://www.prescqipp.info/our-resources/bulletins/bulletin-339-low-priority-prescribing/ (Accessed: 1 December 2025).

PrescQIPP. *Low priority prescribing: Webkit*. Available at: https://www.prescqipp.info/our-resources/webkits/low-priority-prescribing/ (Accessed: 1 December 2025).

PrescQIPP. *Perindopril arginine*. Available at prescqipp.info/search-page/?keyword=perindopril (Accessed 1 December 2025)

UK Government. (2025) *Immunisation against infectious disease: The Green Book*. Available at: https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book#the-green-book (Accessed: 1 December 2025).

UK Government. (2025) *Medicines Health Regulatory Agency*. Available at: https://www.gov.uk/drug-device-alerts (Accessed: 1 December 2025).

University of Nottingham. (2017) *Clothes and eczema project*. Available at: https://www.nottingham.ac.uk/research/groups/cebd/projects/clothes/index.aspx (Accessed: 1 December 2025).

Appendix A – Patient Information Leaflets

Medicine	Patient Information Leaflet
Bath and Shower Preparations	Bath-and-Shower-Preparations-PIL
Dosulepin	Dosulepin-PIL
Doxazosin	Doxazosin-PIL
Herbal Treatments	Herbal-Treatments-PIL
Immediate Release Fentanyl	Immediate-release fentanyl PIL
Lidocaine Plasters	Lidocaine Plasters PIL
Liothyronine	Liothyronine PIL
Needles	Needles-PIL
Omega-3 Fatty Acid Compounds	Omega-3-Fatty-Acid-Compounds-PIL
Oxycodone and Naloxone Combination Products	Oxycodone-and-Naloxone-Combination-Products-PIL

Medicine	Patient Information Leaflet
Rubefacients	Rubefacients-PIL
Trimipramine	Trimipramine PIL