Department of Health | An Roinn Sláinte / Männystrie O Poustie

# Options to restrict or stop the routine prescribing of selected medicines in primary care

## Consultation Document

**Friday 10 July 2026**

# Contents

# Foreword

Medicines play a vital role in preventing, treating and curing disease. They are Northern Ireland's most common medical intervention and are central to supporting health and wellbeing throughout life. However, the cost of medicines continues to rise year on year and now stands at over £870 million annually. Without action, there is a real risk that the Health and Social Care (HSC) system will struggle to fund new and innovative treatments, particularly in the context of an ageing population and increasing demand for services.

Despite ongoing efforts to improve the efficient and appropriate use of medicines, prescribing rates and costs per person in Northern Ireland remain consistently higher than in other parts of the United Kingdom. Further action is needed to ensure medicines remain both affordable and effective in delivering the best possible outcomes for patients.

In September 2025, the Department of Health published *Valuing Medicines: A Strategy for the Sustainable Use of Medicines in Northern Ireland*. This strategy provides a framework for improving the use of medicines across the HSC, ensuring they add value to health, are cost-effective, and sustainable.

A key recommendation within the strategy is to review the prescribing of low-priority medicines including those with poor evidence of effectiveness and medicines available over the counter for minor conditions. While progress has been made, £7.3 million was spent in primary care in 2024/25 on medicines included on the 'Limited Evidence' and 'Stop' lists, in addition to the costs associated with producing prescriptions such as General Practitioners (GPs) and practice staff time. Continued funding of such items may represent a lower priority when compared with evidence-based treatments and services.

Reducing reliance on medicines considered having low and limited clinical value will help improve value for money, reduce waste, strengthen clinical effectiveness and support the long-term sustainability of the HSC. This consultation therefore seeks

views on proposed actions to restrict or stop the prescribing of these medicines from GP practices in primary care.

I encourage all those who may be directly affected by these proposals, as well as those who have direct or indirect influence on prescribing decisions, to take the opportunity to respond to this consultation. This includes general practitioners, community pharmacy teams, other healthcare professionals, health and social care providers, those working across the HSC sector, community and voluntary organisations, and members of the public.

Your input is vital in ensuring that any decisions regarding potential changes to the prescribing of selected medicines, which Departmental guidance considers having low and limited clinical value, from GP practices in primary care are informed by a broad range of perspectives, experiences, and expertise. By contributing your views, you will help support a balanced and informed approach to future prescribing policy.

**Professor Cathy Harrison**

**Chief Pharmaceutical Officer**

# Consultation details

The Department is seeking your views on the proposals contained within this consultation document. The Department acknowledges that the proposals set out in this consultation document will have an impact on peoples' lives and it recognises the need to keep the public informed on such important matters and to allow people the opportunity to comment on these policy proposals.

## Topic

This consultation seeks views on options to restrict or stop the prescribing of selected medicines, which Departmental guidance considers having low and limited clinical value, from GP practices in primary care in Northern Ireland, including those with poor evidence of effectiveness and medicines available over the counter for minor conditions.

## Scope

We are keen to hear the views of all those who may be directly affected by these proposals, as well as those who have direct or indirect influence on prescribing decisions, such as general practitioners, community pharmacy teams, other healthcare professionals, HSC providers, those working across the HSC sector, community and voluntary organisations, and members of the public.

## How to respond

This consultation document is available on the Department's website at www.health-ni.gov.uk/consultations. It seeks your views on the options presented at **Section 3**.

If you wish to comment on the proposals contained within this consultation, please complete the Citizen Space online response questionnaire using the link or QR Code below. Citizen Space is the Northern Ireland Civil Service (NICS) recommended online consultation tool and preferred surveying tool.

LINK

Please note that it is advised that respondents should first read this consultation document before attempting to respond to the consultation questions.

If you should require the consultation response questionnaire in an alternative format, please contact the Department using the enquiries details below.

## Enquiries

For any enquiries in relation to this consultation please contact the Department using the following details:

Email: VMSconsultation@health-ni.gov.uk

Write: Valuing Medicines Consultation
Room D4.10
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

## Timing

This consultation will run for 12 weeks, starting on **Friday 10 July and closing on Friday 2 October 2026**.

Following the close of the consultation, the Department will analyse responses and a report will be published on the Department's website

## Privacy notice

We respect your privacy. Any personal information you provide will be handled in accordance with data protection laws. We will not publish your personal details.

Being transparent and providing accessible information to individuals about how we may use personal data is a key element of the Data Protection Act (DPA) and the EU General Data Protection Regulation (GDPR). The Department is committed to building trust and confidence in our ability to process your personal information and protect your privacy. For information on how we process your information, please see the privacy notice in **Annex A**.

## Impact screening

The policy proposals contained in this consultation paper have been subject to interim equality impact screening in line with Section 75 of the Northern Ireland Act 1998. This screening has not identified any significant adverse impacts on any of the Section 75 categories, nor any human rights issues at this stage.

Consideration has also been given to the needs of individuals living in rural communities. The Department has concluded that the proposals are not expected to impact people in rural areas differently from those in urban areas, and that a full Rural Needs Impact Assessment is not required at this stage.

These interim screening documents are available alongside this consultation on the Department's website and on Citizen Space. They will be kept under review and updated to reflect any views or evidence received during the public consultation process. In addition, any requirement for a Regulatory Impact Assessment will be considered as an outcome of the consultation exercise.

# **Section 1:** Background

## Valuing Medicines Strategy

The Department of Health launched "Valuing Medicines: A strategy for the sustainable use of medicines in Northern Ireland[1]" in September 2025. The Valuing Medicines Strategy (VMS) sets out a plan to ensure medicines are used in a way that is effective, sustainable, and delivers the best outcomes for patients and the health service. The VMS examined six key areas, focusing on the increasing use of medicines in Northern Ireland (NI) and the challenges this presents for affordability, sustainability and patient outcomes:

- **Optimising the benefits of medicines**
- **Social and demographic issues**
- **Access to new medicines**
- **Medicines safety issues**
- **Environmental issues**
- **Economic issues**

A total of twenty recommendations were identified to support the delivery of the strategy's aim to embed sustainable medicines practice into all Health and Social Care (HSC) settings. Within this context, VMS Recommendation 1.2 proposed consultation on actions to restrict or stop the prescribing of low-priority medicines in General Practitioner (GP) practices in NI including those with poor evidence of effectiveness and medicines available over the counter for minor conditions.

## Current legal and contractual position on GP prescribing in Northern Ireland

GP practices in NI provide General Medical Services (GMS) under contractual arrangements commissioned and managed by the Department's Strategic Planning

[1] Valuing Medicines: a strategy for the sustainable use of medicines in Northern Ireland

and Performance Group (SPPG). GPs are independent providers of services and are not employees, partners or agents of the SPPG.[2]

The legal framework governing prescribing within GP practices in NI is established through a combination of primary and secondary legislation. The overarching statutory authority derives from the **Health and Personal Social Services (Northern Ireland) Order 1972**[3], which provides the legislative basis for the provision of GMS.

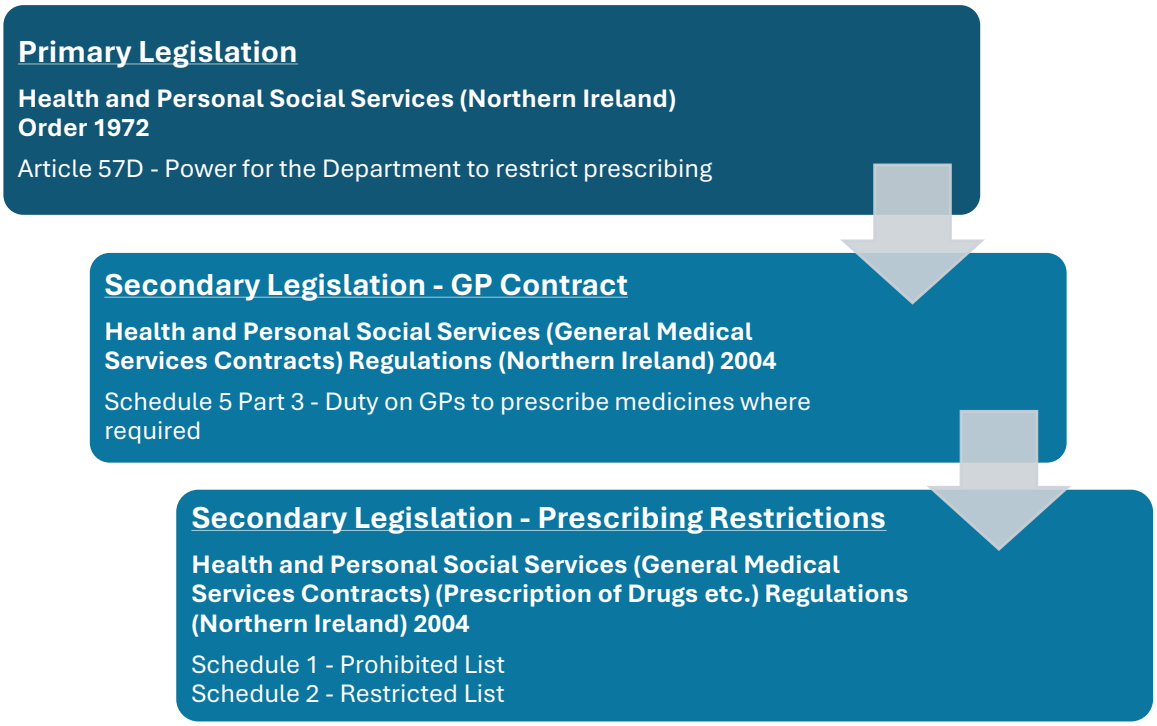
In general, GPs and other appropriate prescribers operating under GMS contractual arrangements may prescribe any drugs, medicines, or appliances required for a patient's treatment, and prescribers retain professional discretion in determining clinical need. However, the legislation also provides mechanisms through which the Department may restrict or prohibit the prescribing of certain medicines under the GMS contract.

In particular, the powers provided under **Article 57D of the 1972 Order**[4] enable the Department to specify drugs, medicines, or other substances that may not be prescribed under the contract, or that may only be prescribed in defined circumstances.

These powers are implemented through secondary legislation, principally the **Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004**[5] and the **Health and Personal Social Services (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations (Northern Ireland) 2004**[6]. Together, these regulations establish the contractual framework for GP practices providing services under the GMS contract and set out the rules governing prescribing, including circumstances in which particular medicines may be restricted or prohibited.

[2] Health and Social Care: General Practitioners (GPs)
[3] Legislation.gov.uk: Health and Personal Social Services (Northern Ireland) Order 1972
[4] Legislation.gov.uk: Health and Personal Social Services (Northern Ireland) Order 1972 - Article 57D
[5] Legislation.gov.uk: The Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004
[6] Legislation.gov.uk: Health and Personal Social Services (General Medical Services Contracts) (Prescription of Drugs Etc) Regulations (Northern Ireland) 2004

**Figure 3.1: Legal framework governing GP prescribing in NI**




The **Health and Personal Social Services (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations (NI) 2004**,[7] ("the 2004 Regulations") contain two lists of drugs, medicines and other substances which either:

- cannot be prescribed under the GMS contract (**Schedule 1** – "the prohibited list")[8], or
- may only be prescribed in limited circumstances (**Schedule 2** – "the restricted list")[9].

GP practices providing services under the GMS contract must comply with these legislative requirements. If they fail to do so they could be judged to be in breach of their contract.

[7] Legislation.gov.uk: Health and Personal Social Services (General Medical Services Contracts) (Prescription of Drugs Etc) Regulations (Northern Ireland) 2004
[8] Legislation.gov.uk: Health and Personal Social Services (General Medical Services Contracts) (Prescription of Drugs Etc) Regulations (Northern Ireland) 2004: SCHEDULE 1
[9] Legislation.gov.uk: Health and Personal Social Services (General Medical Services Contracts) (Prescription of Drugs Etc) Regulations (Northern Ireland) 2004: SCHEDULE 2

## Prescribing guidance

Specific NI guidance is periodically issued to GP practices by the Department and the SPPG, via the Northern Ireland Formulary web site[10], on the advisability of prescribing certain items with limited evidence of efficacy or for the treatment of minor self-limiting illnesses some of which may be purchased over the counter (OTC) at low cost.

Included in this guidance is the periodic production by the SPPG of a deprescribing list. This list is divided into two sections[11]:

- A **Limited Evidence** list; and
- A **Stop list.**

There are no restrictions on GP practices who fail to abide by this guidance, and prescribers can still use their clinical discretion when prescribing. If refusal to prescribe was challenged by a patient, it would be up to the prescriber to defend their actions as Departmental letters and SPPG guidance have no statutory base.

## Costs

In 2024/25, approximately £7.3 million was spent in NI on medicines included on the Limited Evidence and Stop lists. This comprised £6.1 million on Limited Evidence list items, and £1.2 million on Stop list items. **Annex B** provides a more detailed breakdown of expenditure on medicines included on these lists from 2017/18 to 2024/25.

In addition to the direct cost of these medicines, there are wider resource implications associated with their prescribing, including GP and practice staff time.

[10] Northern Ireland Formulary: Prescribing Stop List

[11] Northern Ireland Formulary: Stop and Limited Evidence List

## **Section 2:** Development of options for consultation

While medicines deliver substantial benefits, the VMS highlights that some prescribing offers limited or no clinical value, may expose patients to avoidable harm, and diverts finite resources from higher value interventions. It also contributes to negative environmental impacts. Despite this, the prescribing of such items continues across NI, resulting in avoidable expenditure and misalignment with the Department's cost-effective prescribing policies.

Although deprescribing guidance is in place and there has been some progress made in reducing prescribing in this area, it is non-statutory, and prescribers retain full clinical discretion. As a result, variation in prescribing practice persists, and items less suitable for prescribing or available over the counter continue to be prescribed.

Other UK jurisdictions have taken steps to reduce low value prescribing and improve consistency in clinical practice. NHS England has adopted a more directive approach, supported by national lists of items that should not be routinely prescribed and expectations around deprescribing[12]. NHS Wales[13][14] has taken a more advisory and evidence-based approach, focusing on supporting clinicians to reduce low value prescribing through guidance and data. NHS Scotland[15] has developed a broader, strategic and system wide framework, combining prescribing restrictions with wider sustainability goals and an emphasis on person centred care.

Overall, the other UK jurisdictions demonstrate that reducing prescribing of low and limited clinical value medicines can be addressed through different balances of national direction, clinical autonomy and system wide policy frameworks. Notably, no other UK jurisdiction has introduced formal legislative restrictions specifically to limit the prescribing of items considered to be of low clinical value, limited evidence, or poor cost effectiveness.

---

[12] NHS England (2023, updated 2025): Items which should not routinely be prescribed in primary care: policy guidance

[13] NHS Wales (2017 – 2020): Items which should not routinely be prescribed in primary care: policy guidance

[14] AWTTC notes that the resource was assessed for review in September 2025 and that an updated version is expected later in 2026

[15] Scottish Government (2024): Medicines - achieving value and sustainability in prescribing: guidance

However, existing legislation provides the Department with powers to restrict or prohibit the prescribing of specific medicines under the GMS contract, including through the use of defined prohibited and restricted lists. While these mechanisms are currently in place, they have not been applied to the categories of low and limited clinical value medicines considered in this consultation.

In this context, there is an opportunity to consider whether further action should be taken in NI to strengthen existing arrangements. The Department is therefore seeking views on potential options to restrict or stop the prescribing of medicines included on the Limited Evidence and Stop lists from GP practices. These include items with limited clinical effectiveness and those readily available over the counter. The following section sets out these options for consultation.

# **Section 3:** Options

The Department of Health has identified the following options to restrict or stop the prescribing of selected medicines, which Departmental guidance considers having low and limited clinical value, in primary care in NI.

## Option 1 - Do nothing

Under this option, the current arrangements would remain in place. The Stop and Limited Evidence lists would continue to operate as guidance only and would not be incorporated into legislation or formal contractual requirements, limiting the extent to which prescribers can lawfully restrict access to treatments.

Prescribing decisions would continue to be based on individual clinical judgement without additional restriction or guidance, and ongoing variation in prescribing practice is likely to persist.

**Financial Impact**

Prescribing is likely to continue at broadly current levels, particularly for Stop List items, with limited additional savings anticipated in the prescribing budget.

## Option 2 – Issue a letter of comfort and strengthened guidance to primary care leads about conditions for which OTC items should not be prescribed in Primary Care

Under this option, the SPPG would issue a formal letter of comfort to primary care leads, reinforcing that GMS contractors are required to have regard to deprescribing guidance issued. It would clarify that contractors may follow this guidance and use their professional judgement to decide when prescribing OTC items is appropriate or not, without risk of breaching contractual requirements.

Such a letter to GP practices in NI may provide sufficient reassurance to support decisions not to prescribe certain OTC items on the list without introducing formal restrictions. It could also reinforce the expectation that GP practices have regard to SPPG guidance in this area and encourage more consistent application of the guidance. The use of newly developed HSC Position Statements and patient information materials could further support and clarify the message for prescribers and patients.

HSC Position Statements will focus on items which lack evidence of clinical effectiveness, where more cost-effective alternatives are available, or which are available over the counter for minor conditions. The statements will also provide supporting rationale, recommendations for clinicians, and guidance for patients and carers, and will apply across both primary and secondary care settings.

This approach would not introduce formal contractual prohibitions, but prescribers within GP practices would be expected to have regard to guidance when making prescribing decisions. The impact of this option would be dependent on voluntary compliance, and continued variation in prescribing behaviour is still considered likely as the extent to which prescribers can lawfully restrict access to treatments would remain unchanged.

**Financial Impact**

While difficult to quantify, there is the potential for modest savings, depending on uptake. Savings are not guaranteed and may be limited in scale.

## Option 3 - Amend Schedule 1 and Schedule 2 of the 2004 Regulations to include selected products from the Stop and Limited Evidence lists

Under this option, it is proposed to amend **Schedule 1 (the prohibited list)** and **Schedule 2 (the restricted list)** of the 2004 Regulations to include selected items from the Stop List and the Limited Evidence List, where this is considered clinically appropriate.

The aim of this approach is to:

- Provide greater clarity and certainty for GP practices when making prescribing decisions;
- Promote consistency in prescribing practices; and
- Support the effective and appropriate use of resources within the prescribing budget.

It is important to note that **not all items from the Stop List and Limited Evidence List will necessarily be included**. Final decisions on inclusion will be informed by clinical assessment and evidence review.

**Proposed Changes**

**(a) Amendment to Schedule 1 (Prohibited List)**

It is proposed that the Department of Health would amend Schedule 1 to include selected products listed on the Stop List.

- These amendments would apply locally and would be independent of arrangements in other UK jurisdictions.
- Once included in Schedule 1, these items must not be prescribed by prescribers operating within GP practices.
- Inclusion in Schedule 1 provides a clear legal basis for prescribers to refuse to prescribe these items under the GMS contract.
- Failure to comply with these restrictions may result in a GP practice being found in breach of their terms of service, which could lead to disciplinary action, including potential disqualification.

**Annex C** sets out the proposed list of products to be transferred from the Stop List into Schedule 1.

**Financial impact:**

Based on the 2024/25 prescribing data, it is estimated that restricting prescribing for these items could result in savings of approximately **£460k per annum.**

**(b) Amendment to Schedule 2 (Restricted List)**

It is also proposed that the Department would amend Schedule 2 to include selected products from the Limited Evidence List.

- These amendments would also apply locally and be independent of the rest of the UK.
- Once included in Schedule 2, these items may only be prescribed in defined clinical circumstances.
- Prescribing would remain subject to professional clinical judgement, but within specified restrictions.

For example:

- Quinine may be restricted for use in the treatment of malaria or severe/chronic muscle cramps, but not for minor, self-limiting conditions.

As with Schedule 1, failure to comply with the restrictions may result in a GP practice being in breach of contractual obligations.

**Annex C** provides the proposed list of items to be added from the Limited Evidence list to Schedule 2.

**Financial impact:**

Due to the limited but continued permitted use of these medicines, it is not possible to provide a definitive estimate of savings. However, total expenditure on the proposed Limited Evidence List items in the previous year was approximately **£4.7 million**.

## Option 4 - Hybrid Approach – Amend Schedule 1 of the 2004 Regulations to include selected items from the Stop list, and apply a targeted approach to Limited Evidence list items

Under this option, it is proposed to adopt a hybrid approach by:

- Amending **Schedule 1 (the prohibited list)** of the 2004 Regulations to include **selected** items from the Stop List; and
- Applying a targeted, non-legislative approach to items on the Limited Evidence List, supported by strengthened prescribing guidance and the expanded use of HSC Position Statements.

This approach seeks to balance clarity and enforceability for products that should not be prescribed, with clinical flexibility for products where prescribing may still be appropriate in certain circumstances.

The intended outcomes are to:

- Provide clear direction and certainty to GP practices where prescribing is not appropriate;
- Support consistent and evidence-based prescribing decisions; and
- Retain flexibility for clinicians where clinical judgement is required.

**Proposed Changes**

**(a) Amendment to Schedule 1 (Prohibited List)**

It is proposed that the Department of Health would amend Schedule 1 to include selected products included on the Stop List.

- These amendments would apply locally and would be independent of arrangements in other UK jurisdictions.
- Once included in Schedule 1, these items must not be prescribed by prescribers operating within GP practices.
- Inclusion in Schedule 1 provides a clear legal basis for prescribers to refuse to prescribe these items under the GMS contract.

- Failure to comply with these restrictions may result in a GP being found in breach of their terms of service, which could lead to disciplinary action, including potential disqualification.

**Annex C** sets out the proposed list of products to be transferred from the Stop List into Schedule 1.

**Financial impact:**

Based on the 2024/25 prescribing data, it is estimated that restricting prescribing for all Stop List items could result in savings of approximately **£460k per annum.**

**(b) Targeted Approach for Limited Evidence List**

For products included on the Limited Evidence List, it is proposed to adopt a targeted approach, rather than introducing formal legislative restrictions through Schedule 2.

This approach would include:

- The expanded use of HSC Position Statements to clearly define the clinical circumstances in which prescribing is considered appropriate; and situations where prescribing should not routinely occur.
- The provision of clinical guidance and prescribing advice to support GP practices in applying these recommendations in practice.

Under this model:

- Prescribers would retain clinical discretion, but within a clearer framework of evidence-based guidance.
- Position statements would promote consistency in prescribing decisions, while allowing for individual patient need and clinical judgement.

Unlike Schedule 2 restrictions, this approach would not introduce formal contractual prohibitions, but GP practices and other primary care prescribers would be expected to have regard to the guidance when making prescribing decisions.

**Financial impact:**

As prescribing would still be permitted in defined circumstances, it is not possible to provide a definitive estimate of savings. The introduction of clearer guidance is expected to reduce inappropriate prescribing and generate some level of cost savings.

## Patient impact and mitigations

Although the medicines included within the proposed restrictions are currently considered to have limited or no clinical value when prescribed under HSC arrangements, the Department recognises that changes to prescribing arrangements may affect some patients who are currently receiving them. Any implementation would be supported by a clear communication plan, appropriate clinical review, shared decision-making and a patient-centred approach to care. Patients would be offered advice on suitable alternative treatments, self-care approaches and support available through community pharmacy services. Where appropriate, deprescribing would be undertaken in a planned and clinically supervised manner to ensure that changes are made safely and with due regard to individual patient needs and circumstances.

The Department is committed to ensuring that the views of patients, carers, healthcare professionals and other stakeholders are fully considered. Responses received through this consultation will be carefully analysed and will help inform decisions on the most appropriate way forward. Should changes be taken forward, further engagement with healthcare professionals, patients, representative organisations and the wider public will form an important part of the implementation process, helping to ensure that any changes are introduced safely, effectively and with appropriate support for those affected.

# **Annex A:** Privacy Notice

## Privacy Notice – Consultations (Department of Health)

Data Controller Name: Department of Health

Address: Castle Buildings, Stormont, BELFAST, BT4 3SG

Email: VMSconsultation@health-ni.gov.uk

Telephone: 02890523146

Data Protection Officer Name: Charlene Maher

Email: DPO@health-ni.gov.uk

Being transparent and providing accessible information to individuals about how we may use personal data is a key element of the Data Protection Act (DPA) and the UK General Data Protection Regulation (UK GDPR). The Department of Health is committed to building trust and confidence in our ability to process your personal information and protect your privacy.

**Purpose for processing**

While we are not seeking to process personal data as part of this consultation and would encourage you to be mindful of the information you disclose as part of your responses, if you disclose any personal data we will ensure we process this according to the requirements of Data Protection law. We will process any data provided in response to consultations for the purpose of informing the development of our policy, guidance, or other regulatory work in the subject area of the request for views. We will publish a summary of the consultation responses and, in some cases, the responses themselves but these will not contain any personal data. We will not publish the names or contact details of respondents but will include the names of organisations responding.

If you have indicated that you would be interested in contributing to further Departmental work on the subject matter covered by the consultation, then we might process your contact details to get in touch with you.

**Lawful basis for processing**

The lawful basis we are relying on to process your personal data is Article 6(1)(e) of the UK GDPR, which allows us to process personal data when this is necessary for the performance of our public tasks in our capacity as a Government Department.

We will only process any special category personal data you provide, which reveals racial or ethnic origin, political opinions, religious belief, health or sexual life/orientation when it is

necessary for reasons of substantial public interest under Article 9(2)(g) of the UK GDPR, in the exercise of the function of the department, and to monitor equality.

**How will your information be used and shared?**

We process the information internally for the above stated purpose. We don't intend to share your personal data with any third party. Any specific requests from a third party for us to share your personal data with them will be dealt with in accordance with the provisions of the data protection laws.

**How long will we keep your information?**

We will retain consultation response information until our work on the subject matter of the consultation is complete, and in line with the Department's approved Retention and Disposal Schedule Good Management, Good Records (GMGR).

**What are your rights?**

- You have the right to obtain confirmation that your data is being processed, and access to your personal data
- You are entitled to have personal data rectified if it is inaccurate or incomplete
- You have a right to have personal data erased and to prevent processing, in specific circumstances
- You have the right to 'block' or suppress processing of personal data, in specific circumstances
- You have the right to data portability, in specific circumstances
- You have the right to object to the processing, in specific circumstances
- You have rights in relation to automated decision making and profiling.

How to complain if you are not happy with how we process your personal information
If you wish to request access, object or raise a complaint about how we have handled your data, you can contact our Data Protection Officer using the details above.

If you are not satisfied with our response or believe we are not processing your personal data in accordance with the law, you can complain to the Information Commissioner at:

Information Commissioner's Office

Wycliffe House

Water Lane

Wilmslow

Cheshire SK9 5AF

ICO Complaints Form

# **Annex B:** Primary care expenditure on Limited Evidence and Stop list items in NI, 2017/18 - 2024/25

## Data Sources and Limitations

The data presented in this paper is based on prescribing data derived from administrative sources. The following points should be noted when interpreting the findings:

- The data is sourced from the Family Practitioner Services[16] (FPS) Pharmacy Payment System.

- The Pharmacy Payment System enables the Business Services Organisation (BSO) to make payments to pharmaceutical contractors for dispensing prescription items that have been prescribed in primary care (e.g. by General Practitioner, Nurse Practitioner, Dentist, Podiatrist) as well as through the Pharmacy First scheme available in a number of pharmacies.

- As a result, the dataset reflects dispensed items across primary care and is not limited to prescriptions issued by General Practitioners alone, unless otherwise stated.

- The analysis is based on items included on the Limited Evidence and Stop Lists between August 2025 and April 2026. Items added to these lists after May 2026 are not reflected in the analysis and will be considered separately following consultation.

- Not all products currently included on the Limited Evidence and Stop Lists were present for the full duration of the analytical period. Items may have been added to the lists over time, and this should be considered when interpreting trends.

[16] HSC Business Services Organisation: FPS Pharmaceutical Services

- The data do not include information on the clinical indication for which a medicine was prescribed. For example, while propranolol may be used in the management of anxiety, it is also commonly prescribed for cardiovascular conditions and migraine; it is therefore not possible to isolate prescribing for a specific indication.

- Some items included on the Stop List show little or no recorded prescribing activity within specific financial years. For example, Cubitan recorded no prescribing data in 2024/25. This may reflect changes in clinical practice, product availability, or prior reductions in use.

## Table 1: Total primary care expenditure on Limited Evidence and Stop lists items in NI, 2017/18 - 2024/25 (£millions)

| | **2017/ 18** | **2018/ 19** | **2019/ 20** | **2020/ 21** | **2021/ 22** | **2022/ 23** | **2023/ 24** | **2024/ 25** |
|---|---|---|---|---|---|---|---|---|
| Limited Evidence | £8.4 | £7.7 | £7.7 | £7.4 | £7.1 | £7.1 | £6.8 | £6.1 |
| Stop | £1.3 | £1.4 | £1.5 | £1.2 | £1.2 | £1.2 | £1.2 | £1.2 |
| **Total** | **£9.7** | **£9.0** | **£9.1** | **£8.6** | **£8.3** | **£8.3** | **£8.0** | **£7.3** |

## Table 2: Primary care expenditure on Limited Evidence list items in NI, 2024/25* (£)

| Limited Evidence list items | 2024/25 costs (£) | Percentage of total (%) |
|---|---|---|
| Lidocaine patches | £2,465,547 | 40.7% |
| Bath and Shower Emollients | £784,329 | 13.0% |
| Multivitamins | £717,927 | 11.9% |
| Quinine | £400,487 | 6.6% |
| Liothyronine | £386,309 | 6.4% |
| Omega-3 fatty acid compounds | £376,755 | 6.2% |
| Oxycodone and naloxone combination products | £330,175 | 5.5% |
| Methocarbamol | £277,759 | 4.6% |
| Trimipramine | £129,878 | 2.1% |
| Paracetamol and tramadol combination products (e.g. Tramacet) | £65,854 | 1.1% |
| Migraleve | £61,773 | 1.0% |
| Fentanyl immediate release | £47,465 | 0.8% |
| Aliskiren | £10,598 | 0.2% |
| **Total** | **£6,054,855** | **100.0%** |

** Propranolol is excluded from the analysis, as it is not possible to determine prescribing indication (e.g. anxiety versus other uses).*

## Table 3: Primary care expenditure on Stop list items in NI, 2024/25 (£)*

| Stop list items | 2024/25 costs (£) | Percentage of total (%) |
|---|---|---|
| High fluoride toothpastes[17] | £749,782 | 62.7% |
| Dosulepin | £177,161 | 14.8% |
| Naltrexone (low dose) | £73,303 | 6.1% |
| Low calorie ONS (Ensure® liquid, Fresubin Original®) | £35,947 | 3.0% |
| Ostomy deodorants | £34,945 | 2.9% |
| Probiotics | £28,640 | 2.4% |
| Rubefacients e.g. Movelat® cream/gel | £25,257 | 2.1% |
| Glucose tablets / shots e.g. Lift glucose Juice shots®, Lift Glucose tablets®, Dextro energy®, Lucozade tablets® | £13,960 | 1.2% |
| Preparations for managing blepharitis, e.g. Blephaclean® wipes, Blephagel® and Blephasol® | £13,356 | 1.1% |
| Co-proxamol | £9,445 | 0.8% |
| Eye Supplements | £8,711 | 0.7% |
| Souvenaid® | £6,874 | 0.6% |
| Spatone® | £4,015 | 0.3% |
| IQoro | £3,993 | 0.3% |
| Gluten free non-staple foods | £3,910 | 0.3% |
| Infacol®/Dentinox®/Colief® drops | £1,874 | 0.2% |
| Gamolenic acid | £1,463 | 0.1% |
| All glucosamine containing products | £1,345 | 0.1% |
| Green Lipped Mussel (Pernaton gel®) | £1,271 | 0.1% |
| Bio-Oil® | £600 | 0.1% |
| CoEnzyme Q10® | £312 | 0.0% |
| Eye Q® and Efalex® | £211 | 0.0% |
| **Total** | **£1,196,374** | **100.0%** |

**Cubitan recorded no prescribing data in 2024/25*

[17] The majority of primary care expenditure on high-fluoride toothpastes relates to dental prescribing rather than prescribing under GMS contractual arrangements. GP practice prescribing accounted for £15,559 in 2024/25.

## Table 4: Primary care expenditure on Limited Evidence list items, 2017/18 – 2024/25 (£)

| | 2017/2018 | 2018/2019 | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023 | 2023/2024 | 2024/2025 |
|---|---|---|---|---|---|---|---|---|
| Aliskiren | 40,989 | 34,981 | 27,239 | 24,507 | 21,558 | 21,883 | 21,040 | 10,598 |
| Bath and Shower Emollients | 1,201,015 | 1,131,265 | 1,154,859 | 1,132,982 | 1,133,853 | 1,126,217 | 1,030,639 | 784,329 |
| Fentanyl immediate release | 243,915 | 226,981 | 145,958 | 137,993 | 108,593 | 75,622 | 58,991 | 47,465 |
| Lidocaine patches | 2,438,151 | 2,480,276 | 2,500,305 | 2,485,141 | 2,546,087 | 2,478,344 | 2,408,699 | 2,465,547 |
| Liothyronine | 777,021 | 602,793 | 577,750 | 548,311 | 487,349 | 433,151 | 397,016 | 386,309 |
| Methocarbamol | 663,302 | 587,768 | 552,842 | 510,110 | 476,186 | 497,702 | 411,310 | 277,759 |
| Migraleve | 103,587 | 63,438 | 40,166 | 57,781 | 59,131 | 60,688 | 60,120 | 61,773 |
| Multivitamins | 782,601 | 715,122 | 745,910 | 753,153 | 759,471 | 903,124 | 863,661 | 717,927 |
| Omega-3 fatty acid compounds | 526,056 | 473,446 | 438,301 | 419,430 | 412,200 | 409,880 | 402,233 | 376,755 |
| Oxycodone and naloxone combination products | 574,764 | 535,320 | 484,600 | 441,931 | 408,103 | 386,979 | 347,207 | 330,175 |
| Paracetamol and tramadol combination products (e.g. Tramacet) | 124,587 | 76,022 | 61,742 | 58,882 | 52,649 | 45,567 | 53,340 | 65,854 |
| Quinine | 257,926 | 235,626 | 425,695 | 451,010 | 288,044 | 341,130 | 514,306 | 400,487 |
| Trimipramine | 620,434 | 533,239 | 496,747 | 407,561 | 332,102 | 282,765 | 250,204 | 129,878 |
| **Total** | **8,354,350** | **7,696,278** | **7,652,116** | **7,428,793** | **7,085,327** | **7,063,051** | **6,818,764** | **6,054,855** |

## Table 5: Primary care expenditure on Stop list items, 2017/18 – 2024/25 (£)

| | 2017/2018 | 2018/2019 | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023 | 2023/2024 | 2024/2025 |
|---|---|---|---|---|---|---|---|---|
| Probiotics, e.g. VSL#3®, Vivomixx®, lactobacillus | 125,014 | 99,981 | 59,458 | 43,657 | 39,060 | 35,324 | 33,291 | 28,640 |
| Bio -Oil® | 1,325 | 752 | 490 | 697 | 743 | 393 | 684 | 600 |
| Preparations for managing blepharitis, e.g. Blephaclean® wipes, Blephagel® and Blephasol® | 44,227 | 43,484 | 39,585 | 33,519 | 29,448 | 19,341 | 17,157 | 13,356 |
| CoEnzyme Q10 | 427 | 261 | 266 | 83 | 78 | 282 | 293 | 312 |
| Colic products, e.g. Infacol® or Dentinox® | 7,917 | 4,544 | 4,577 | 5,098 | 4,790 | 2,762 | 2,197 | 1,874 |
| Comfort milks (Aptamil®, Cow & Gate® and SMA®) or Colief® drops | 6,765 | 6,419 | 2,927 | 3,542 | 3,045 | 776 | - | - |
| Co-proxamol | 50,031 | 29,631 | 12,839 | 18,816 | 15,121 | 15,809 | 15,006 | 9,445 |
| Cubitan® | 444 | - | - | - | - | 17 | - | - |
| Dosulepin | 107,851 | 224,359 | 420,767 | 381,908 | 276,526 | 228,894 | 199,821 | 177,161 |
| Eye supplements, e.g. Icaps®, Ocuvite®, Macushield®, PreserVision®, Viteyes® | 32,321 | 25,441 | 20,173 | 16,948 | 14,195 | 12,223 | 10,804 | 8,711 |
| Gamolenic acid / evening primrose oil | 26,619 | 16,876 | 12,301 | 11,890 | 8,572 | 2,992 | 1,893 | 1,463 |
| Glucosamine containing products | 8,553 | 7,642 | 8,645 | 7,659 | 5,990 | 5,384 | 3,804 | 1,345 |
| Glucose tablets / shots, e.g. Lift glucose Juice shots®, Lift Glucose tablets®, Dextro energy®, Lucozade tablets®, Glucotabs® Note: this does not apply to oral glucose gel. | 26,794 | 30,484 | 19,410 | 13,916 | 14,007 | 13,354 | 14,505 | 13,960 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Gluten free non -staple foods, e.g. biscuits, sausage rolls | 8,497 | 7,591 | 6,666 | 6,671 | 6,200 | 5,769 | 5,365 | 3,910 |
| Green-lipped mussel (Pernaton gel®) | 20,848 | 10,312 | 4,765 | 4,118 | 4,030 | 10,093 | 3,111 | 1,271 |
| High fluoride toothpastes, e.g. Duraphat® 2800ppm or 5000ppm fluoride toothpaste, sodium fluoride 0.619% or 1.1% dental paste SF | 463,549 | 503,690 | 569,526 | 389,972 | 556,720 | 654,178 | 719,486 | 749,782 |
| IQoro® neuromuscular training device | - | - | - | - | - | 3,872 | 4,477 | 3,993 |
| Naltrexone (low dose) | 104,273 | 82,773 | 77,063 | 69,435 | 72,547 | 57,377 | 59,791 | 73,303 |
| Omega-3 fish oils, e.g. Omacor®, MaxEPA®, Eye Q® and Efalex® | 594 | 622 | 398 | 213 | 140 | 240 | 230 | 211 |
| Low calorie oral nutritional supplements (1kcal/ml or less) | 98,522 | 75,129 | 65,441 | 60,756 | 50,475 | 61,128 | 51,958 | 35,947 |
| Ostomy deodorants | 43,590 | 40,867 | 40,783 | 39,850 | 41,897 | 41,734 | 42,644 | 34,945 |
| Rubefacients, e.g. Movelat gel/cream®, Transvasin®, Deep Heat® | 117,367 | 115,128 | 109,320 | 80,450 | 61,934 | 42,958 | 30,790 | 25,257 |
| Souvenaid® | 21,298 | 16,980 | 10,311 | 7,833 | 9,232 | 5,605 | 6,437 | 6,874 |
| Spatone | 14,041 | 8,685 | 7,234 | 6,231 | 5,688 | 5,798 | 4,758 | 4,015 |
| **Total** | **1,330,865** | **1,351,651** | **1,492,942** | **1,203,263** | **1,220,437** | **1,226,304** | **1,228,501** | **1,196,374** |

## Table 6: Expenditure on GP prescribing of high fluoride toothpastes, 2017/18 – 2024/25 (£)

| | **2017/2018** | **2018/2019** | **2019/2020** | **2020/2021** | **2021/2022** | **2022/2023** | **2023/2024** | **2024/2025** |
|---|---|---|---|---|---|---|---|---|
| High fluoride toothpastes | 22,458 | 24,063 | 26,307 | 26,074 | 23,368 | 19,889 | 16,483 | 15,559 |

# **Annex C:** Proposed items to be added to Schedule 1 and Schedule 2

Table 1 lists the products currently on the Stop List, along with the explanatory rationale, which could be considered for addition to Schedule 1 following a clinical review for appropriateness.

## Table 1: Proposed list of products to be transferred from the Stop List into Schedule 1

| **Products that can be purchased OTC** | |
|---|---|
| **Gluten-Free Non-Staple Foods** | Only staple foods should be supplied on prescription as per Coeliac UK and SPPG guidance. Items which are not consistent with healthy eating advice, such as biscuits, cakes, muffins, pasties, sausage rolls, should not be supplied on HS21 prescription. |
| **Infacol® or Dentinox® or Colief® drops** | There is no good evidence that infantile colic is caused by excess intestinal gas. Therefore, Infacol® or Dentinox® Colic Drops (simeticone) should not be prescribed, as evidence for these products is lacking. There is no good evidence that transient lactase deficiency either occurs, or that it could cause infantile colic. Hence there is no evidence to support prescribing of Colief® Drops. |
| **Comfort Milk** | There is no evidence to support prescribing of a partially hydrolysed, low-lactose formula (comfort formula) such as Aptamil Comfort ® and Cow&Gate Comfort First® milks. Comfort milks are not on the ACBS list and therefore should not be prescribed on HS21 prescription. |
| **Supplements for Age-related Macular Degeneration** | E.g. Icaps®, Ocuvite®, Macushield®, PreserVision®, Viteyes® Evidence for effectiveness of supplements for AMD is weak. A SPPG letter was issued in February 2016 advising that supplements for AMD should not be prescribed on the Health Service. This advice is supported by optometrists in the SPPG Optometry Practice Newsletter. |
| **Spatone®** | The BNF recommends that the oral dose of elemental iron for iron deficiency is 100 to 200mg daily. Spatone® contains 5mg of ferrous iron per sachet and is therefore inadequate for the treatment of proven iron deficiency. If |

| | |
|---|---|
| | iron supplementation is indicated a full therapeutic dose should be used. |
| **Bio-Oil®** | This product is marketed for improvement of the appearance of scars, stretch marks and uneven skin tone, but availability of large randomised controlled trials (RCTs) is lacking. Bio-Oil is not on the ACBS list and therefore should not be prescribed on HS21 prescription. |
| **Preparations for blepharitis** | E.g. Blephaclean®, Blephagel®, Blephasol®<br>Refer to Treatment of Blepharitis patient information leaflet in Northern Ireland Formulary website for tips on how to control or manage blepharitis. |
| **Green Lipped Mussel (GLM) (Pernaton Gel®)** | GLM is a source of omega fatty acids which has been used as an adjunctive treatment in the symptomatic management of osteoarthritis, but there is currently limited evidence of efficacy. There is no evidence to suggest that GLM is effective for rheumatoid arthritis. |
| **Co-enzyme Q10** | NICE guideline CG181 states: “Do not offer coenzyme Q10 to increase adherence to statin treatment.” Studies which evaluate the effect of CoQ10 in improving adherence to statins are currently lacking which is why NICE do not recommend its use. |
| **Glucose tablets / shots (note: this does not apply to oral glucose gel)** | E.g. Lift Glucose Juice shots®, Lift Glucose tablets®, Dextro energy®, Lucozade tablets®, and Glucotabs®. These products should not be prescribed. Patients can purchase glucose preparations or use alternatives to treat their hypo, e.g. jelly babies. Refer to Diabetes UK for patient information leaflets on management of ‘hypos’. Glucose preparations are not on the ACBS list and therefore should not be prescribed on HS21 prescription. |
| **Glucosamine and Chondroitin** | NICE do not recommend prescribing glucosamine or chondroitin for osteoarthritis as evidence of benefit is limited. This advice is reflected in the NI Formulary and a HSCB letter on glucosamine sent out in Oct 2010. |
| **Gamolenic Acid / Evening Primrose Oil** | Gamolenic acid is found in evening primrose oil which was previously available for the treatment of atopic eczema and mastalgia before the product licences were withdrawn in 2002 due to lack of sufficient efficacy data. No large trials are available to confirm its efficacy for pre-menstrual syndrome, rheumatoid arthritis or multiple sclerosis. |
| **Cubitan®** | Cubitan® is a high protein, high energy nutritional supplement for the dietary management of patients with |

| | |
|---|---|
| | chronic wounds. It is not on the ACBS list and therefore should not be prescribed on HS21 prescription. |
| **Probiotics** | ACBS recently removed VSL#3® and Vivomixx® from the Drug Tariff as a review of the evidence did not sufficiently demonstrate that the products are clinically effective. There are therefore no indications where probiotics are recommended for prescribing within the HSC. |
| **Rubefacients** | E.g. Movelat gel/cream®, Transvasin Heat Rub®, Deep Heat Rub/spray® There is limited evidence that rubefacients work. The BNF says that the evidence does not support the use of rubefacients in short- or long-term muscle pain. In addition, CKS states that there is no evidence for the use of rubefacients in the management of osteoarthritis. Rubefacients can be bought from a pharmacy or supermarket. |
| **IQoro® neuromuscular training device** | The IQoro® device has been advocated to strengthen the muscles of the oropharynx, oesophagus and diaphragm, potentially reducing the symptoms of conditions such as hiatus hernia and dysphagia. IQoro® has been advocated for treatment of stroke related dysphagia, hiatus hernia as well as snoring, sleep apnoea and speech issues. However, there is limited evidence available to support the use of IQoro® currently. |
| **Omega 3 Fatty Acids Products for brain power, etc.** | E.g. EyeQ® and Efalex® Products containing omega-3 fatty acids, alone or in combination with other supplements are sometimes promoted for a range of neurological conditions including attention deficit hyperactivity disorder (ADHD) and autism in children, but the evidence to support this is sparse. |
| **Souvenaid®** | There is some evidence that Souvenaid® may improve memory function in people in the early stages of Alzheimer's disease (treatment naïve people). However, trials were not able to show any effect on the ability to slow or prevent cognitive decline. The Alzheimer's Society issued a statement to say that patients would be better spending their money on regular exercise, as this is a far more effective way of reducing cognitive decline, and that NHS money would be better spent on other treatments for Alzheimer's disease. Souvenaid® is not on the ACBS list and therefore should not be prescribed on HS21 prescription. |
| **Ostomy deodorants** | In accordance with PrescQIPP guidance ostomy deodorants should not be routinely prescribed for patients with a stoma as there is no clinical need. If a bag |

| | |
|---|---|
| | is fitted correctly and has a good seal around the stoma no odour should be apparent except for when the bag is being emptied or changed. For odour when emptying or changing their stoma bag, patients could consider buying an inexpensive air freshener to mask toilet odour. |
| **Low calorie oral nutritional supplements (1kcal/ml or less)** | Adult ready to drink oral nutritional supplements providing 1kcal/ml (e.g. Ensure® liquid and Fresubin® Original) are low calorie supplements. They are not cost effective and should not be prescribed. Patients that only require a small additional nutritional intake should instead be advised how to manage using fortified food. |
| **Products that are not available to purchase OTC** | |
| **Co-proxamol** | Co-proxamol was withdrawn from the UK market in 2007 due to safety concerns. All use in the UK is now on an unlicensed basis. An alternative analgesic should be prescribed if appropriate. |
| **High fluoride toothpastes** | E.g. Duraphat® 2800ppm or 5000ppm fluoride toothpaste, sodium fluoride 0.619% or 1.1% dental paste sugar free. High fluoride content toothpastes are used to reduce the risk of dental caries in those patients who are at increased risk of developing caries. High concentration fluoride toothpaste should only be prescribed by a dentist following clinical assessment and as part of an overall dental health management plan. GPs should not commence any patients on these products and current prescribing should be stopped and patients referred to a dentist for clinical assessment. |
| **Naltrexone (low dose)** | Low dose naltrexone (3mg to 4.5mg daily) is an unlicensed treatment. It has been used anecdotally to improve some symptoms of multiple sclerosis, but evidence to support its use is lacking. Refer to HSCB letter (January 2017) for further information. GPs should not start new patients on this treatment. Existing patients should be reviewed and treatment stopped if not beneficial to the patient. Where there is any uncertainty, the initiating specialist should be consulted. |
| **Dosulepin** | Dosulepin should not be prescribed as evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose. Therefore, dosulepin should not be initiated in primary care for any indication and existing patients should be reviewed for suitability for switching to a safer agent. This may require consultation with a specialist. Dosulepin should not be stopped abruptly unless serious side effects have occurred. |

Table 2 lists the products currently on the Limited Evidence list, along with the explanatory rationale, which could be considered for addition to Schedule 2 following a clinical review for appropriateness.

## Table 2: Proposed list of products to be transferred from the Limited Evidence List into Schedule 2

| | |
|---|---|
| **Quinine** | The MHRA advise that quinine is not a routine treatment for nocturnal leg cramps, and should only be used when cramps regularly disrupt sleep. Treatment should be interrupted every 3 months to reassess. Review tool is available on Primary care intranet. |
| **Omega-3 fatty acid compounds** | NICE NG238 states that omega-3 fatty-acid compounds should not be offered*, either alone or in combination with a statin, for the primary or secondary prevention of cardiovascular events as their use is not supported by clinical evidence; prescribing such supplements is not a cost-effective use of limited resources. The MHRA (Jan 2024) also states that there is a dose-dependent increased risk of atrial fibrillation in patients with established cardiovascular diseases or cardiovascular risk factors; patients should be advised to seek medical advice and to stop taking the medicine if symptoms develop.<br>Icosapent ethyl is an exception to this if used as described in NICE TA805 guidance on icosapent ethyl with statin therapy for reducing the risk of cardiovascular events in people with raised triglycerides. |
| **Vitamins** | E.g. Forceval®, multivitamins, ascorbic acid, Ketovite®, vitamins BPC, Vivioptal®, cod liver oil, riboflavin (B2)*, niacin (B3)*, pyridoxine (B6)*. Vitamins may be prescribed to prevent or treat deficiency, but NOT as dietary supplements or non-ACBS approved indications. Patients should be given dietary advice instead. Refer to Northern Ireland Formulary for further guidance on prescribing of vitamins. |
| **Lidocaine patches** | The NICE guideline on neuropathic pain does not make a recommendation on the use of lidocaine patches as a treatment option, due to limited clinical evidence supporting its use. Lidocaine patches may be considered in post herpetic neuralgia if the patient is intolerant of first line systemic therapies or where they have been ineffective or are contra-indicated. A review audit is available on the Primary care intranet. |

| | |
|---|---|
| **Liothyronine (including Armour® Thyroid and liothyronine combination products)** | The majority of people with hypothyroidism can be managed with levothyroxine. However, a small proportion of patients treated with levothyroxine continue to suffer with symptoms despite adequate biochemical correction. For these people, liothyronine may be used on the recommendation of a Health Service endocrine specialist in secondary care — prescribers in primary care should not initiate liothyronine. Recommendations from private healthcare consultants to GPs to prescribe should not occur. Note: liothyronine is also indicated for patients with thyroid cancer, in preparation for radioiodine ablation, iodine scanning, or stimulated thyroglobulin test. A shared care guideline is available on the Interface Pharmacy website. |
| **Methocarbamol** | Methocarbamol is licensed as a short-term adjunct to the symptomatic treatment of acute musculoskeletal disorders associated with painful muscle spasms. It is listed in the BNF as 'less suitable for prescribing' as evidence for its use in muscle spasm or spasticity is limited. |
| **Fentanyl immediate release (IR) (tablets, lozenges, film, nasal spray)** | IR fentanyl is licensed for the treatment of breakthrough pain in adults with cancer who are already receiving at least 60mg oral morphine daily or equivalent. Use in palliative care by a recognised multidisciplinary team professional is acceptable and appropriate patients should not have the medicine deprescribed at this point. The amount of IR fentanyl being prescribed however makes it likely that in many cases it is being used for other types of pain than cancer. IR fentanyl can cause addiction. |
| **Aliskiren** | Aliskiren is not recommended for primary hypertension, due to insufficient clinical and cost-effectiveness data. Insufficient evidence of its effectiveness to determine its suitability for use in resistant hypertension. In addition, the MHRA has reported on a risk of adverse outcomes (hypotension, syncope, stroke, hyperkalaemia and change in renal function including acute renal failure) when aliskiren is combined with ACE inhibitors or angiotensin II receptor blockers, especially in patients with diabetes and those with impaired renal function. Aliskiren should therefore only be used if initiated and under review by secondary care. |